

**THE PROFESSIONAL DEVELOPMENT OF BLACK SOUTH AFRICAN NURSES
1908–1994: A HISTORICAL PERSPECTIVE**

by

JOHANNA MARIA ESTERHUIZEN

submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF GH VAN RENSBURG

CO-SUPERVISOR: MRS JE TJALLINKS

November 2012

To Ian, François and Jo-Anne

Student number: 3009 5158

DECLARATION

I declare that **THE PROFESSIONAL DEVELOPMENT OF BLACK SOUTH AFRICAN NURSES 1908–1994: A HISTORICAL PERSPECTIVE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



Johanna Maria Esterhuizen

14 December 2012

Date

THE PROFESSIONAL DEVELOPMENT OF BLACK SOUTH AFRICAN NURSES

1908–1994: A HISTORICAL PERSPECTIVE

STUDENT NUMBER: 3009 5158
STUDENT: JOHANNA MARIA ESTERHUIZEN
DEGREE: MASTER OF ARTS
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR: PROF GH VAN RENSBURG
CO-SUPERVISOR: MRS JE TJALLINKS

ABSTRACT

The early professional history of black South African nurses has not been the principal focus of local historians. Consequently, a qualitative historical inquiry was conducted into the available literature on the economic, social, political and cultural factors that influenced the professional development of black South African nurses from 1908–1994. Non-probability, purposive sampling assisted in assembling a corpus of historically rich data for analysis using time-specific *a priori* codes. The findings revealed that; culturally, black South African nurses had to adapt to a Western-dominated scientific health view; educationally, they had to master specialised formal Western terminology presented in a ‘foreign’ language (English) and, socio-politically, they had to adapt to being regarded as an elitist middle-class in the black community while remaining marginalised in the white-dominated workplace. Recommendations include expanding the historical research base, designing more effective strategies for promoting cultural sensitivity, and prioritising the focus on teaching and student retention.

Key terms:

Black South African nurses; nursing history; historical inquiry; *a priori* periods; 1908–1994; socio-economic, cultural, political, and professional development; nursing students.

ACKNOWLEDGEMENTS

I wish to thank the following persons for their contributions to this dissertation:

- My husband, Ian, for his unwavering support and patience during the past three years. I am your greatest fan.
- My children, Francois and Jo-Anne, for allowing mommy “quiet time”.
- My parents, for the solid foundation you provided all my life.
- My heartfelt thanks you to my supervisor, Prof GH van Rensburg, for her willingness to listen to my ideas, direct my thoughts and encourage my writing.
- A special word of thank you to my co-supervisor, Mrs JE Tjallinks, for her words of personal support and professional encouragement when I needed it most.
- My colleagues, for sharing my enthusiasm when I discovered the ‘newest’ old book or article.
- My students, for awakening my curiosity.
- My dear friend Phyllis, for helping me understand South African legislation.
- The staff of the South African Institute of Race Relations’ archives, for providing the archival documents used in chapters 3 and 4 of this dissertation.
- The staff of the UNISA library in Pretoria, for finding the literature requested.
- Mr A Harold, the editor, for his expert editing of this dissertation.

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1	INTRODUCTION	1
1.2	BACKGROUND TO THE RESEARCH PROBLEM.....	2
1.2.1	Source of the problem.....	2
1.2.2	Background to the problem.....	3
1.3	RESEARCH PROBLEM.....	6
1.3.1	Problem statement.....	6
1.4.	AIM OF THE STUDY	7
1.4.1	Research purpose.....	7
1.4.2	Justification for the selected historical period 1908–1994	7
1.4.3	Research objectives.....	8
1.5	SIGNIFICANCE OF THE STUDY	8
1.6	DEFINITION OF CONCEPTS.....	9
1.7	FOUNDATIONS OF THE STUDY.....	10
1.8	RESEARCH DESIGN	11
1.9	RESEARCH METHODS	11
1.9.1	Population	11
1.9.2	Sample selection.....	12
1.9.3	Data collection	12
1.9.4	Data analysis	13
1.10	DESIGN VALIDITY	13
1.11	ETHICAL CONSIDERATIONS.....	14
1.12	SCOPE AND LIMITATIONS OF STUDY	15
1.13	CONCLUSION	15

Table of contents	Page
--------------------------	-------------

CHAPTER 2

METHODOLOGY

2.1	INTRODUCTION.....	16
2.2	RESEARCH DESIGN	16
2.2.1	Research problem.....	20
2.2.2	Research purpose.....	20
2.2.3	Research objectives.....	21
2.3	RESEARCH METHODS	21
2.3.1	Population	21
2.3.2	Sample selection.....	23
2.3.3	Data collection	25
2.3.4	Data analysis	28
2.4	DESIGN VALIDITY	31
2.5	ETHICAL CONSIDERATIONS.....	35
2.6	CONCLUSION	37

CHAPTER 3

NURSING UNDER CONTROL OF THE MEDICAL COUNCILS: 1908–1944

3.1	INTRODUCTION.....	39
3.2	HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER	40
3.3	THE BIRTH OF A PROFESSION	42
3.3.1	Nursing history before 1908: the British influence.....	42
3.3.2	Voluntary registration status for South African professional nurses.....	42
3.3.3	The Victorian family structure: its influence on nursing.....	43

Table of contents	Page
3.3.4 Religion and the image of nursing.....	45
3.3.4.1 Sister Henrietta Stockdale: religious and a lady.....	45
3.4 EDUCATED AFRICAN “LADIES” NEEDED.....	47
3.4.1 European and African health care systems in the early twentieth century.....	47
3.4.2 Entering a European-styled health care system with an African educational background.....	48
3.4.3 The state of formal black education in the former Union of South Africa.....	49
3.4.3.1 Black schools in the former Union of South Africa: issues of cost and accessibility.....	49
3.4.3.2 The influence of black school education on the development of black professional nurses in the former Union of South Africa.....	51
3.4.4 The cultural and social divide.....	52
3.4.4.1 European nurses encounter cultural and social challenges in South Africa.....	52
3.4.4.2 Black South African nurses: caught between two cultures.....	52
3.4.5 Early efforts to increase the number of black professional nurses.....	54
3.4.5.1 The debate about the category ‘lesser trained nurse’.....	54
3.4.5.2 Working conditions in hospitals.....	55
3.4.5.3 Limited nursing student posts.....	56
3.4.6 The second Anglo Boer War: the socio-economic impact on nursing after the war.....	56
3.5 NURSES IN SOUTH AFRICA: ISSUES OF POWER AND STATUS.....	57
3.5.1 The political and economic climate post World War I (WW I).....	57
3.5.2 Women’s social role after WW I.....	59
3.5.3 Nurses seek professional independence.....	59
3.5.3.1 The drive to establish a South African nursing association.....	60
3.5.3.2 SATNA campaigns for nursing representation on the South African Medical Council (SAMC).....	60
3.5.4 SATNA objectives and stance towards black professional nurses.....	61
3.5.4.1 The 1932 Bloemfontein Congress.....	62
3.5.4.2 Nursing entry requirements are raised.....	63

Table of contents	Page
3.5.4.3 SATNA changes its position regarding a lower qualification for less well-trained black nurses	64
3.5.4.4 Black professional nurses' reaction to SATNA.....	66
3.6 WORKING CONDITIONS, TRAINING AND WORKING OPPORTUNITIES: 1908–1944.....	67
3.6.1 Limited nursing training opportunities for black women	67
3.6.1.1 Limited training opportunities place a burden on qualified black nurses	68
3.6.2 Barriers to black nurses completing their training	71
3.6.2.1 Early efforts to train and employ more black nurses	72
3.7 BLACK NURSE PIONEERS: 1908–1944	73
3.7.1 Lovedale Nursing School produces the first black registered nurse	74
3.7.2 The first black nurses qualifying at McCord Nursing Home	74
3.7.3 Black nursing pioneers recognised by the SANA.....	74
3.8 IN SUMMARY: THE HISTORICAL ERA 1908–1944	76
3.9 CONCLUSION	77

CHAPTER 4

SOUTH AFRICAN NURSING 1945–1970s: STATUTORY INDEPENDENCE AND APARTHEID

4.1 INTRODUCTION.....	79
4.2 HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER	80
4.3 THE INFLUENCE OF WORLD WAR II ON THE DEVELOPMENT OF BLACK PROFESSIONAL NURSING IN SOUTH AFRICA	82
4.3.1 South African politics before and during WW II.....	82
4.3.2 Socio-economic conditions during WW II.....	83
4.3.3 Socio-political changes evident by 1948	84
4.3.4 WW II changes the system of nursing in South Africa	86
4.3.5 The need for black nurses.....	87

Table of contents	Page
4.4 SOUTH AFRICAN POLITICS: APARTHEID AND THE POLICY OF SEPARATE DEVELOPMENT ...	88
4.4.1 The beginning of apartheid	89
4.4.2 Black South Africans react to the system of apartheid.....	90
4.4.3 The influence of apartheid on the development of the nursing profession.....	91
4.5 SOCIOCULTURAL FACTORS INFLUENCING THE ENTRY OF BLACK PERSONS INTO THE NURSING PROFESSION.....	91
4.5.1 The number of black girls receiving secondary education during World War II.....	92
4.5.2 The socio-economic and health status of black people: 1950s–1970s	92
4.5.3 The social status of black nurses in South Africa: 1950s–1970s	94
4.5.4 The married nurse.....	96
4.5.5 The financial status of black nurses in South Africa: 1950s-1970s	97
4.6 SECONDARY BLACK EDUCATION IN APARTHEID SOUTH AFRICA.....	97
4.6.1 Secondary black education 1950s–1970s	97
4.6.2 The effect of the Bantu education system on nursing	99
4.7 SANC INFLUENCE ON NURSING REGISTRATION AND TRAINING	100
4.7.1 SANC legislation in the 1940s.....	101
4.7.2 SANC legislation: 1950s to 1960s.....	102
4.7.3 SANC legislation in the 1970s.....	105
4.7.4 Black nurses available in South Africa by 1975	106
4.7.5 Black nurses being trained in South Africa by 1978.....	107
4.8 THE POLITICS OF NURSING	108
4.8.1 The effect of <i>Nursing Act 69</i> of 1957.....	109
4.8.2 Homeland nursing.....	112
4.8.3 Striking as a method of protest	112
4.9 NURSING TRAINING 1940s–1970s.....	113
4.9.1 Training facilities for black nurses 1940–1970s	114

Table of contents	Page
4.9.2 Educational qualifications needed to enter nursing.....	114
4.9.3 University training for black nurses in South Africa.....	115
4.10 CONCLUSION	116

CHAPTER 5

SOUTH AFRICAN NURSING 1970s-1994: STRIVING TOWARDS DEMOCRACY AND UNITY

5.1 INTRODUCTION.....	118
5.2 HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER	119
5.3 SOUTH AFRICA FROM THE 1970s TO 1994: A HISTORICAL PERSPECTIVE	120
5.3.1 Issues of black labour and economy: 1970s–1980s	120
5.3.2 The South African political climate: 1970s–1990s.....	121
5.4 THE INFLUENCE OF THE POLITICAL CLIMATE ON SANA AND SANC	124
5.4.1 The influence of the ICN on the promulgation of the Nursing Act (50 of 1978).....	124
5.4.2 The changing roles of SANC and SANA as defined by the Nursing Act (50 of 1978).....	125
5.5 THE SOCIAL STATUS AND ROLE OF BLACK NURSES: 1970s–1990s	128
5.5.1 The social status of black nurses in comparison with the social status of the black population in the 1970s and 1980s.....	128
5.5.2 The social status of black nurses in the 1990s.....	129
5.6 THE EFFECT OF SECONDARY AND TERTIARY EDUCATION ON BLACK NURSING STUDENTS 1970s–1994.....	131
5.6.1 The influence of politics, culture and the secondary education system.....	131
5.6.2 Changes in nursing education: 1970s–1994.....	133
5.6.3 The new nursing education structure created barriers for black nursing candidates	134
5.7 CHALLENGES FACING BLACK NURSES IN 1994	137

Table of contents	Page
5.8 CONCLUSION	138
 CHAPTER 6 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS	
6.1 INTRODUCTION.....	139
6.2 PURPOSE OF THE STUDY	140
6.3 CONCLUSIONS.....	141
6.3.1 Cultural factors that influenced the development of black South African nurses.....	143
6.3.2 Socio-economic factors that influenced the development of black South African nurses	144
6.3.3 Political factors that influenced the development of black South African nurses.....	145
6.3.4 Educational factors that influenced the development of black South African nurses	147
6.4 SCOPE AND LIMITATIONS	151
6.5 RECOMMENDATIONS.....	151
6.5.1 Recommendations for further historical research.....	151
6.5.2 Recommendations regarding teaching strategies	152
6.5.3 Recommendations regarding cultural sensitivity in the health care system	153
6.5.4 Recommendations for further research.....	153
6.5.5 Recommendations regarding recruitment and retention of students.....	154
6.6 CONCLUSION	155
LIST OF REFERENCES	156

List of tables	Page
Table 4.1 Total numbers of black student nurses and midwives (excluding university students) 1974–1976	107
Table 6.1 Factors influencing the professional development of black South African nurses: 1908–1994	150

List of figures	Page
Figure 2.1	Schematic representation of the historical research process 17
Figure 3.1	Schematic representation of the <i>a priori</i> periods discussed in this dissertation..... 40
Figure 3.2	Schematic representation of the topics discussed in the <i>a priori</i> period: 1908–1944 41
Figure 4.1	Schematic representation of the <i>a priori</i> periods discussed in this dissertation..... 80
Figure 4.2	Schematic representation of the topics discussed in the <i>a priori</i> period: 1945–1970s 81
Figure 4.3	An example of a schematic representation of the growth of African nurses 1900–1977 111
Figure 5.1	Schematic representation of the <i>a priori</i> periods discussed in this dissertation..... 118
Figure 5.2	Schematic representation of the topics discussed in the <i>a priori</i> period: 1970s–1994 120
Figure 6.1	Schematic representation of the <i>a priori</i> periods discussed in this dissertation within the context of the research methodology..... 142

List of abbreviations

AAHN	American Association for the History of Nursing
ANC	African National Congress
BTNA	Bantu Trained Nurses' Association
DENOSA	Democratic Nursing Organisation of South Africa
ICN	International Council of Nurses
MEDUNSA	Medical University of South Africa
NCHE	National Commission on Higher Education
NECC	National Education Crisis Committee
NP	National Party
SAMC	South African Medical Council
SANA	South African Nursing Association
SANC	South African Nursing Council
SATNA	South African Trained Nurses' Association
SAVV	Suid-Afrikaanse Verpleegstersvereniging
SRC	Student Representative Council
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNISA	University of South Africa
USA	United States of America
WHO	World Health Organization
WW I	World War I
WW II	World War II

List of annexures	Page
--------------------------	-------------

Annexure A	Ethical clearance from the Department of Health Studies, Unisa
------------	--

Annexure B	Examples of check lists to confirm external and internal criticism of data sources
------------	--

Annexure C	Declaration of researcher's ethical compliance
------------	--

Annexure D	Reflection
------------	------------

Annexure E	Editor's declaration
------------	----------------------

CHAPTER 1

INTRODUCTION TO THE STUDY

“First, in their everyday activities nurses are writing history. They do it, for example, when they write a report on a patient. Of course, they believe themselves to be writing about the present; but at the moment that they put pen to paper, they describe the past, no matter how recent”
(Kruman 1985:109).

1.1 INTRODUCTION

Giordano (1996:178) poses the rhetorical question, “If you don’t know where you came from, how do you know where you are going?” Historiography, a retrospective analysis of historical events, provides humankind with knowledge of the past. Such knowledge, in turn, provides people with a sense of belonging and pride, and assists individuals in defining themselves. More importantly, it gives them insight into the issues that face their society today. Indeed, only if the past is known and understood, can a society imagine new ideas and values that will shape its future. Therefore the *implications* of a historical event are more important than the event itself (Galgano, Arndt & Hyser 2008:1–2; Glass 1998:356; Lewenson & Hermann 2008:2; Mellish 1990:3; Streubert Speziale & Carpenter 2003:208).

The term *historiography* refers to a researcher’s endeavours to think about historical events and then to reconstruct these events by searching for available evidence in places such as libraries, archives and private collections. These reconstructed recordings of historical events must be presented within the context of the time they occurred in; not in the present. Thus the burden of the historian is that one cannot reconstruct historical events without a thorough knowledge of the time period in question and an understanding of the norms and values that shaped that society (Galgano et al 2008:1–2; Glass 1998:356; Lewenson & Hermann 2008:2).

Currently, nurses of European extraction, such as Florence Nightingale and Henrietta Stockdale, dominate the historical landscape of South African nursing. Although their valuable contribution to the nursing profession is unquestionable, there is a need to analyse the developmental history of *all* nurses, including that of black South African nurses (Mortimer & McGann 2005:1; 9). While the history of white European nurses

has been extensively documented, that of black South African nurses is less evident in the South African nursing literature. The need to explore and record the history of black nurses is therefore self-evident. This dissertation focuses on the history of black South African nurses, with reference to the historical social, political, economic and cultural influences that shaped their professional development.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The research problem originated from personal observation, discussions with students and the researcher's keen interest in South African history.

1.2.1 Source of the problem

In classroom discussions about the historical versus the current professional role of nurses, it became evident that students had very little knowledge of South African nursing history: Henrietta Stockdale and Cecelia Makiwane were names they had heard before in lectures, but they were unable to explain what contributions these historical figures had made to the nursing profession.

In the researcher's experience, fellow nurse educators are mainly knowledgeable about the history that describes the influence of nineteenth-century European women on South African nursing. This is also the history described in most of the current nursing-history literature; therefore, it is self-evident that the most available sources will result in the knowledge most frequently taught. However, the current young student generation, like Generation X (born 1965-1981), are sceptical about institutions and what they teach and represent (Lancaster 2004:4). Indeed, in the researcher's experience, they tend to be highly critical of much of what they are taught.

Furthermore, the students are often from a culture different from that of the nurse educator and therefore do not necessarily share the nurse educator's interest in European history and culture. Consequently, in the absence of historical material the students can relate to culturally, the nurse educators' European nurses-oriented lectures appear to be irrelevant to their target audience. The locus of the problem is that current literature still emphasises the history of nineteenth-century European

nurses in South Africa but fails to validate the unique history of black South African nurses.

1.2.2 Background to the problem

International authors such as Mortimer and McGann (2005:9), Hargreaves (2008:39) and Holmes (2008:101) state that few historical documents are used in nursing research or considered as a source when nurse educators prepare lectures. In fact, most nurse educators view historical inquiry as irrelevant. It is the researcher's observation as a practising nurse educator involved in nursing education associations and related activities that this apparent disregard for professional history occurs in South Africa as well.

Most fellow nurse educators value and advocate the teaching of nursing history, but neither they nor their students seem to understand why this should be so. This explains why the most recent initiatives to record and discuss post-colonial South African nursing history stem from European (British) nurse historians. Furthermore, a cursory glance at the curricula of two South African nursing courses revealed that first-year students are merely required to write a short paragraph about Dora Nqiza and Cecelia Makiwane. The third-year learners are required to discuss Florence Nightingale and Henrietta Stockdale comprehensively. In the two-page specific objectives of the third year-nursing history module, only one objective requires the learners to describe the "development of nurses in black nations". Clearly, South African nurse historians need to show interest in their local nursing history by researching, documenting and teaching it (Hargreaves 2008:39; Holmes 2008:101; Mortimer & McGann 2005:9).

To the researcher, it seems as if both South African nurse educators and their students are unable to relate to the early struggles of European nursing pioneers to establish nursing as a profession. Rather, these pioneers are viewed as individuals belonging to a different era and a socio-political society which were indifferent to the needs of the majority of the South African population. Marks (1994:14) affirms this observation when she describes the South African 1991 centenary nursing-registration celebrations and states that black nurses were expected to celebrate the achievements of an "ardent pro-imperial Anglican nun who had never considered training a black woman as a nurse". Marks' view, which appears to be held by many of South Africa's black nurses, is in

stark contrast to the admiration that many white South African nurses have for Henrietta Stockdale. She was the Anglican nun who commenced nursing training in this country and whose work and drive led to nurses in the Colony of the Cape of Good Hope being the first in the world to achieve registration for nurses – thereby establishing nursing as a profession in South Africa (Mellish, Brink & Paton 2009:47; Searle 1991:6).

These two opposing views of the same historical event illustrate the complexity of generating interest in South African nursing history among nursing students and educators. However, it should be asked how black nurses can be expected to develop an interest in South African nursing history if the history taught almost totally excludes (with the possible exception of Cecilia Makiwane) historical and cultural role models, as well as information about their professional development which they may be able to identify with.

Holmes (2008:102) states that history becomes irrelevant as time passes because the factors influencing situations are different. The current generation of students are mostly from the Generation X and Millennial groups. In contrast to the traditionalists, the Generation Xers (born 1965-1981) and Millennials (born 1982-2000) are sceptical and critical about institutions and what they represent. Therefore, South African nursing institutions of learning should take note that the younger generations of students might well ask how the hundred-year-old history of white European nurses contributes to the modern millennial way of life and nursing in South Africa (Lancaster 2004:4).

Political and social developments have the potential to change the role of nursing as a profession. Certainly, the political changes in South Africa, which culminated in the 1994 democratic elections, and the accompanying social changes have affected the South African nursing profession. In the light of these changes, European nursing history appears distant and unrelated; yet it is still this history that is dominant in South African nursing curricula (Hargreaves 2008:33; Holmes 2008:103; Mandela 1995:732).

Currently, the nursing history of South African nurses for the period 1908–1994 is recorded in two parallel versions: one as told by nurse historians of European ancestry (such as Prof Charlotte Searle) and others as told by African nurse historians (such as Prof T Mashaba and Dr M Buthelezi). Sweet and Digby (2005:120) state that the South African nursing history has to reflect its entire people and not just a segment of them.

Thus there is a need to record nursing history in a way that is representative of *all* South African nurses; irrespective of culture or race. The existence of such an inclusive written document would make the challenge of teaching the history of nursing to the current generation of students more rewarding as it would be a history that the majority could relate to.

While each of the two historical versions (European and African) acknowledge the existence of the other, they are very different in their explanation of the events that influenced the development of the South African nursing profession from 1908–1994. It is two sides of the same coin, but depending on which author is read; only one side of the coin (the European or African view) is presented. In fact, Buthelezi (2004:1–6) points out that only 15 pages of Searle’s 418 page book, *“History and Development of Nursing from 1652 to 1960”*, written in 1965, is devoted to the development of African nurses. She argues that nurses in South Africa belonged to a divided profession; with the result that little or no learning about the uniquely South African nursing history took place apart from who Cecelia Makiwane was and what she did when she became a registered nurse. South African students and nurse educators alike tend to view the experiences of European nursing pioneers as “nice to know” (Sweet & Digby 2005:121).

Holmes (2008:101) comments that the Australian nursing profession is focused on skills that increase productivity and, in the process, the sheer pleasure of obtaining knowledge for knowledge’s sake takes a back seat. Gaining historical knowledge “for knowledge’s sake” might just be what is needed to unite South African nurses from all cultural and ethnic backgrounds.

From the discussion above, it is clear that the dominance of Anglo-European nursing history has little place in South Africa (Mortimer & McGann 2005:9). Therefore South African nurse historians should strive to answer the following questions pertaining to the history of nursing in South Africa prior to 1994.

- How much of black South African nurses’ history is recorded?
- To what extent were black nurses in South Africa trained and treated differently from their white South African counterparts?
- What were the socio-economic, political and cultural factors that influenced the professional development of black nurses in South Africa?

- How did these influencing factors help or hinder the professional development of African nurses?
- Historical views tend to reflect the view of the powerful (Davies 1980:12). If European nursing history is viewed as the history of the traditionally powerful in South Africa, what are the alternative, uniquely South African nursing histories that we would want to teach to the novice nurses of the future?
- Apart from Cecelia Makiwane, which other persons are viewed as historical figures by black South African nurses?

Mellish (1990:2–3) states that the history of the past is irrevocably linked to the future. She encourages nurse educators to evoke in their students a sense of pride in their profession and explains that "... knowledge of a history of their craft is central to nurses' understanding and to their practice within the health care structure". Adderley-Kelly (2008:4) and Hargreaves (2008:32) concur and state that all nurses, despite cultural, gender or social differences, share a core connection that stems from where nursing came from and how it (nursing) arrived at where it is today. Adderley-Kelly (2008:4) refers to the mythological Sankofa bird of wisdom that allows us to move forward by learning from the past, and Boyd and Bright (2007:1029) hold that the "linking of past, present and future ideas creates a sense of continuity and connection over time".

South African nurses need a Sankofa bird that allows them to appreciate the contribution of previous generations of nurses, while continuing to create a professional nursing history that future generation of South African nurses will be proud of.

1.3 RESEARCH PROBLEM

It is evident that there is a need for knowledge that addresses the uniquely South African nursing history which future generations of nurses will be proud of. It is from this need that the problem statement originates.

1.3.1 Problem statement

Current South African nursing literature lacks historically significant analysis of the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994. Few South African nursing

historians have used historical inquiry to record the professional history of black South African nurses (Mortimer & McGann 2005:9–15).

Given that the first African woman registered as a professional nurse in 1908, and that all South African people obtained their political freedom in 1994, it has become necessary to record historical data about the socio-economic, political and cultural factors that influenced the professional development of black nurses in South Africa from 1908 to 1994. As few inclusive sources are available, nurse educators are not adequately equipped to guide the teaching and learning of black South African nursing history.

1.4 AIM OF THE STUDY

The aim of this study is to contribute to recorded South African nursing history by conducting a historical enquiry into and answering the stated research objectives.

1.4.1 Research purpose

The purpose of this study was to explore the nursing literature by means of historical inquiry into the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994 thereby providing guidance in the teaching of an inclusive South African nursing history.

1.4.2 Justification for the selected historical period: 1908–1994

The era 1908–1994 was chosen as it commences with the first black African nurse successfully completing a formal nursing course. Cecilia Makiwane passed her Cape Colonial medical examination on 19 December 1907 and was registered in January 1908 (Searle 1991:97). Therefore, 1908 proved to be the logical point of departure for researching black South African nurses' professional development.

The year 1994 was also of great significance in South Africa as it marked the historical moment when so-called non-white people obtained their political freedom. The birth of true political democracy allowed black people to participate in the decision-making processes of their country for the first time in more than 300 years. The direct effect on

nursing was that the focus of health care changed significantly: primary health care was prioritised; greater access to the public health system was promised to all; previously (racially) segregated health services were consolidated; and the more alternative healing practices, including African traditional healing, were incorporated into the health care services. The changes in South Africa's socio-political landscape thus led to changes in all areas of professional nursing. Consequently, 1994 stands out as the year in which black nurses not only gained their political freedom but the freedom to participate in the decision-making processes that influence their chosen profession. The period 1908–1994 represents the era during which black South African nurses had little or no formal decision-making power in their profession – yet their numbers have increased from two registered nurses in 1908 to, currently, one of the largest professions in South Africa. By 1990, two thirds of the 150 000 nurses registered at the SANC were coloured and black nurses (this excludes the nurses registered with the 'homelands' nursing councils). In the late 1980s, SANC removed the race category from its statistical records; consequently, the exact number of black professional nurses registered by 1994 is unknown (Breier, Wildschut & Mqgqolozana 2009:3, 7, 21; Muller 1985:19).

1.4.3 Research objectives

The research objectives were the following:

- Conduct a historical inquiry into the nursing literature in order to explore the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994.
- Document the abovementioned data in order to guide teaching an inclusive South African nursing history.

1.5 SIGNIFICANCE OF THE STUDY

Mellish et al (2009:39) state the following: "If a profession is to direct its progress realistically it must do so with the full knowledge of the threads of the past which make up today's patterns". In an earlier book, Mellish (1990:2–3) also states that "everything and everyone is related in some way to the past, which also has an influence on the future". Therefore, in considering the contribution of nurses from all ethnic backgrounds

to the professional development of South African nurses, full recognition must be given to the nursing pioneers of European *and* African ancestry.

Communities such as nursing use rituals to bind the previous to the new generation. Without this ritual or link to the past, nurses might find themselves unable to adjust their attitude towards the uncertainties of the future and thus risk losing their unique identity (Graig 1994:237). A critical analysis of the development history of black South African nursing has the potential to provide nurse educators and their students with such a unique identity.

Giordano (1996:178) states that a lack of knowledge regarding their history might hamper nurses in the creative problem-solving process. Nurses will view problems differently if they realise that there are no new problems; only old problems with new names and different angles (Glass 1998:360). By providing the social, economic, political and cultural background, historical inquiry can assist students in understanding the nature of nursing and its development during the period 1908–1994. This knowledge is also necessary to guide nurse educators in integrating this specific nursing history into teaching and learning strategies.

1.6 DEFINITION OF CONCEPTS

For the purpose of this study, the listed concepts are defined as follows:

- *History* is “an interpretation of the past based on the weight of the available evidence” (Galgano et al 2008:1) or a “story of what happened in the past” (Medway’s Pocket English Dictionary 2003:245). It is the opposite of the present: it is times gone by.
- *Historiography* is the study of history, the interpretation thereof and the methodology of inquiry (Galgano et al 2008:6).
- *Historical documents* are the written word, but may include any medium, such as photographs, literature, art or oral history (Maree 2010:73). For the purpose of this study, historical documents are viewed as literature, art, photographs and all types of the written discourse related to nursing.
- *Primary sources* are the original texts preserved in archives, libraries, museums and private collections. Such sources are also referred to as archival data

(Maree 2010:73). They are the documents that provide the historical researcher with the evidence of past events (Kruman 1985:113; Lewenson & Hermann 2008:34).

- *Secondary sources* are the works of other authors who have written about the historical period being studied (Maree & Pietersen 2010:73). Such sources inform the researcher about what has been written before and can serve as a valuable reference to the primary sources (Kruman 1985:113; Lewenson & Hermann 2008:33).
- For the purpose of this study, the concept *nursing training* are defined as formal training in the art of nursing that led to Medical Council registration before 1928 and South African Nursing Council (SANC) registration thereafter (Searle 1991:1010).
- *Students* are described as persons studying at a place of higher learning with the focus of entering a specific profession (Concise Oxford English Dictionary 2004). For the purpose of this study, the word refers to persons studying with the aim of entering the nursing profession.
- *European nurses* are defined as nurses of European descent. The word *European* refers to persons “from Europe” (Concise Oxford English Dictionary 2004; Medway’s Pocket English Dictionary 2003c:176).
- *African nurses* are defined as nurses of African descent. The word *African* refers to persons “from Africa” (Concise Oxford English Dictionary 2004; Medway’s Pocket English Dictionary 2003d:10). For the purpose of this study the phrase *African nurses* refers to black South African nurses only.
- For the purpose of this study, *Black South African nurses* are described as black South African citizens, formally trained in the art of nursing and registered with SANC.

1.7 FOUNDATIONS OF THE STUDY

Historical research is based on the following basic assumptions (Glass 1998:357):

- Studying the past provides information that can be of use in the present.
- Historians believe in the value of retrospective analysis.
- Records written by other authors are available for research.

- The researcher's questions guide him/her in maintaining objectivity.
- Historical research must be clear in context and unbiased.

The historical context of the phenomena being studied must be considered at all times. This constant need to consider the historical context, demands that the qualitative researcher in particular analyse the emerging data using a cyclical approach of collecting, analysing, reflecting and recording data, which will ensure that the research remains true to the research objectives (Galgano et al 2008:3).

1.8 RESEARCH DESIGN

This qualitative study explored the relevant nursing literature by means of historical inquiry in order to identify the economic, social, political and cultural factors that influenced the professional development of black South African nurses during the period 1908–1994.

Although historical research is a disciplined inquiry into past events, it is not based on rules or procedures. In contrast to quantitative and other types of qualitative research, the basic 'steps' in historical research are not sequential and can be completed in any order. To give methodological rigour to the process of reading and writing, the researcher placed the study in a socio-historical context, which is where most of the nursing history written over the past twenty years is to be found (Lewenson & Hermann 2008:13, 17–18, 26).

1.9 RESEARCH METHODS

In the following section, the research methodology is discussed with reference to the population, sampling technique, data collection and data interpretation.

1.9.1 Population

The population of a study refers to everything and everyone connected to the topic of interest. The population may not necessarily refer to people, but to objects that the researcher is interested in studying. In this study, the researcher was interested in nursing literature that provided information about the social, cultural, political and

economic factors which had influenced the professional development of black South African nurses. To ensure that all relevant, accessible nursing literature was considered during the process of historical inquiry, certain inclusion criteria as described in chapter 2, sub-section 2.3.1 were applied (Brink, Van der Walt & Van Rensburg 2006:123; Stommel & Wills 2004:297).

1.9.2 Sample selection

For the purposes of the proposed historical inquiry, non-probability, purposive sampling was used. The focus of the study was not on the sample being representative of the population, but rather on gaining an in-depth knowledge of the phenomenon. The researcher was mindful of the fact that the sample size in this qualitative research would be determined by the quality of the data obtained. Furthermore, data saturation would only occur when the phenomenon being studied was clearly understood and had been fully explored so that no new data emerged from the literature. Therefore the researcher's sample size was only known at the end of the research project when data saturation occurred (Brink et al 2006:136; Stommel & Wills 2004:302).

In this study the researcher carried out an in-depth study of the social, political, economic and cultural factors that influenced the development of black South African nurses during the period 1908–1994. To this effect, non-probability, purposive sampling techniques were used. The advantages and disadvantages of this sampling technique are discussed in chapter 2, sub-section 2.3.2.

1.9.3 Data collection

Historical inquiry is best suited to an unstructured data-collection method. The researcher studied the nursing literature which indicated the economic, social, political and cultural factors that influenced the professional development of black South African nurses. These influencing factors were studied within the context of the time in which they had occurred, and were in no way manipulated to suit a designated framework. This unobtrusive method of data collection is dominant in the qualitative, naturalistic paradigm (Nieuwenhuis 2010b:78–79).

The researcher identified a source, analysed and reflected on the information gleaned from it before recording the findings. This process of analysis, reflection and recording continued in a cyclical pattern until data saturation occurred, which made the inclusion of information-rich documents extremely important. To ensure that historical documents were rich in data, historically sound and authentic, the researcher used a specified list of criteria (see chapter 2, sub-section 2.3.3) that the documents had to meet (Lewenson & Hermann 2008:6; Nieuwenhuis 2010:81–82; Stommel & Wills 2004:302).

1.9.4 Data analysis

Qualitative data analysis is not a specific, recognisable step in the research process, but rather it is part of the cycle of data gathering, analysing and reflection. The aim is to interpret the data and derive meaning from it (Brink et al 2006:184; Nieuwenhuis 2010:100).

In this study, the researcher used *a priori* codes by sub-dividing the years to be studied (1908–1994) into time periods, e.g. 1908–1944. Giving each of these time periods a descriptive label that denoted the historical significance of the period provided a brief insight into the socio-political factors which shaped the era.

The use of *a priori* codes in the form of a given time period allowed flexibility. During data gathering, the time frames assisted in guiding the research, yet did not force the researcher to exclude any influencing factors (other than cultural, economic, social and political) that emerged from the literature. Keeping in mind that the overall aim of the research was to explore South African historical literature and contribute to the knowledge currently available to nurse educators and their students, all factors that influenced the development of black South African nurses had to be included in the study. The use of *a priori* codes is discussed in greater detail in chapter 2, sub-section 2.3.4.

1.10 DESIGN VALIDITY

The validity debate between qualitative and quantitative researchers is ongoing. Qualitative researchers prefer to replace the term *validity* with more descriptive words such as *trustworthiness* or *truth value* which reflect the creative and interpretive nature

of the research method. However, these researchers cannot agree on one term to describe the process and principles of qualitative *validity*, which accounts for the confusing number of terms found in the research literature (Cutcliffe & McKenna 1999:375; Maree & Van der Westhuizen 2010:41; Polit & Beck 2008:536–538). For the purpose of this study, the researcher used the terms *trustworthiness* and *crystallisation*.

Owing to the qualitative, non-traditional nature of historical inquiry, the researcher did not control the research setting or data in any way. However, it is accepted that the interpretation of historical data is always influenced by the researcher's conscious or unconscious opinions and biases. Therefore a certain measure of subjectivity must be presumed. Consequently, in an effort to remove or limit these influences, a hermeneutic approach to the research project was chosen (Brink et al 2006:110; Lewenson & Hermann 2008:154–155). Questions regarding external and internal criticism were answered by means of a check list designed by the researcher and included in chapter 2 (see Annexure B).

In order to achieve crystallisation, the researcher included all factors (social, economic, cultural and political) which might have influenced the development of black South African nurses. To this end, all primary and secondary sources were given an equal opportunity to be included in the proposed study, irrespective of the researcher's preferences and biases.

1.11 ETHICAL CONSIDERATIONS

If social history "... helps to provide perspective, then the types of questions raised will always have political overtones" (Galgano et al 2008:13). The researcher's own views and ideologies might have influenced the interpretation of historical events which occurred during a volatile South African socio-political era. Therefore, the researcher heeded Lewenson and Hermann's (2008:380) advice that all the variables had to be included and that constant reflecting on one own biases were essential to ensuring a truthful interpretation of the historical events. By means of crystallisation, by adhering to a strict ethical code (described in chapter 2, section 2.5), and by writing a reflective narrative (see Annexure D) which allowed bracketing (setting aside any preconceived ideas) to occur, the researcher attempted to accurately represent the factors that influenced the development of black South African nurses during the period 1908–1994.

1.12 SCOPE AND LIMITATIONS OF STUDY

This dissertation is limited to the analysis of available primary and secondary historical records related to the economic, social, political and cultural factors which influenced the development of black South African nurses during the period 1908–1994.

The period prior to 1908 was excluded from the dissertation as few historical texts about African nurses are available, and because the history of European nurses has been comprehensively recorded.

The period after 1994 was also not included in this dissertation. The year 1994 was of momentous socio-political importance in the history of South Africa as it was the year in which South African black people obtained their political freedom. It marked the beginning of a new era in the country's history in which, Indian, coloured and black people (including black nurses) obtained control over their own progress and development (Mandela 1995:732). How they went about this task is a topic deserving of comprehensive historical research. This dissertation focused on the development of black South African nurses during those historical years when they had little or no control over their own professional development.

1.13 CONCLUSION

Many nurse educators and their students regard nursing history as irrelevant. Similarly, many black South African nurses find it difficult to relate to the nursing history currently being taught in nursing curricula. Since 1994, South Africa has experienced major socio-political changes which demand from the country's nurse historians to reconsider the history being taught to nursing students, because the dominance of European nursing history is not appropriate in modern-day, democratic South Africa. An *inclusive*, uniquely South African nursing history, written by local nurse historians is needed.

By means of historical inquiry, the researcher explored the social, political, economic and cultural factors that influenced the development of black South African nurses during the period 1908–1994. Chapter 2 of this dissertation explains the process of historical inquiry and the research principles that were applied during the study.

CHAPTER 2

METHODOLOGY

“... a single piece of writing is frozen text waiting to be reflected upon”
(Ghaye 2007:159).

2.1 INTRODUCTION

Historiography is a researcher's endeavours to reflect on historical events of interest and to reconstruct these events by searching for available, reliable evidence. The reconstructing and recording of the past event must be explained within the context of time past – not present (Brink & Wood 1998:356; Galgano et al 2008:1–2; Lewenson & Hermann 2008:2).

This retrospective analysis of past events provides humankind; and for the purpose of this dissertation, nurses in particular; with knowledge of the past. Such knowledge imbues people with a sense of belonging and pride. It gives nurses insight into the current issues that face their society in general, and the nursing community in particular. Only if the past is known and understood can a society and, by implication, the nursing profession imagine new ideas and values that will shape their future. The reason is that such knowledge helps them to understand where they came from (Brink & Wood 1998:356; Burns & Grove 2009:58; Galgano et al 2008:1–2; Lewenson & Hermann 2008:2). To this end, the researcher focused on the history of black South African nurses and explored the historical factors that influenced their professional development.

2.2 RESEARCH DESIGN

This qualitative study entailed a historical inquiry into the relevant nursing literature in order to explore the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994.

Historical research is an analytical but imaginative process during which the events of the past are examined in order to reconstruct and attempt to explain them. Historians

make cautious assertions about events of the past, but neither they nor their audience can ever be certain that they are correct because their interpretations are based solely on the strength of the available evidence. Therefore, historical inquiry can provide a perspective on phenomena deeply rooted within a culture, but there is always a measure of ambiguity in the analysis (Brink & Wood 1998:365; Galgano et al 2008:1, 3; Kruman 1985:112).

Historical research is a disciplined inquiry into past events. Yet, in contrast to quantitative and other types of qualitative research, it is not performed in sequential steps; rather it is a cyclical process which includes the following actions: the area of interest is identified; questions are raised that can lead to historical inquiry; a working title is formulated; a continuous literature review is performed. Finally the trustworthiness of the data is verified; the data is analysed; and the narrative is written (Burns & Grove 2009:535; Lewenson & Hermann 2008:13, 26; Stommel & Wills 2004:287).

Figure 2.1 below gives a schematic representation of the process of historical inquiry.

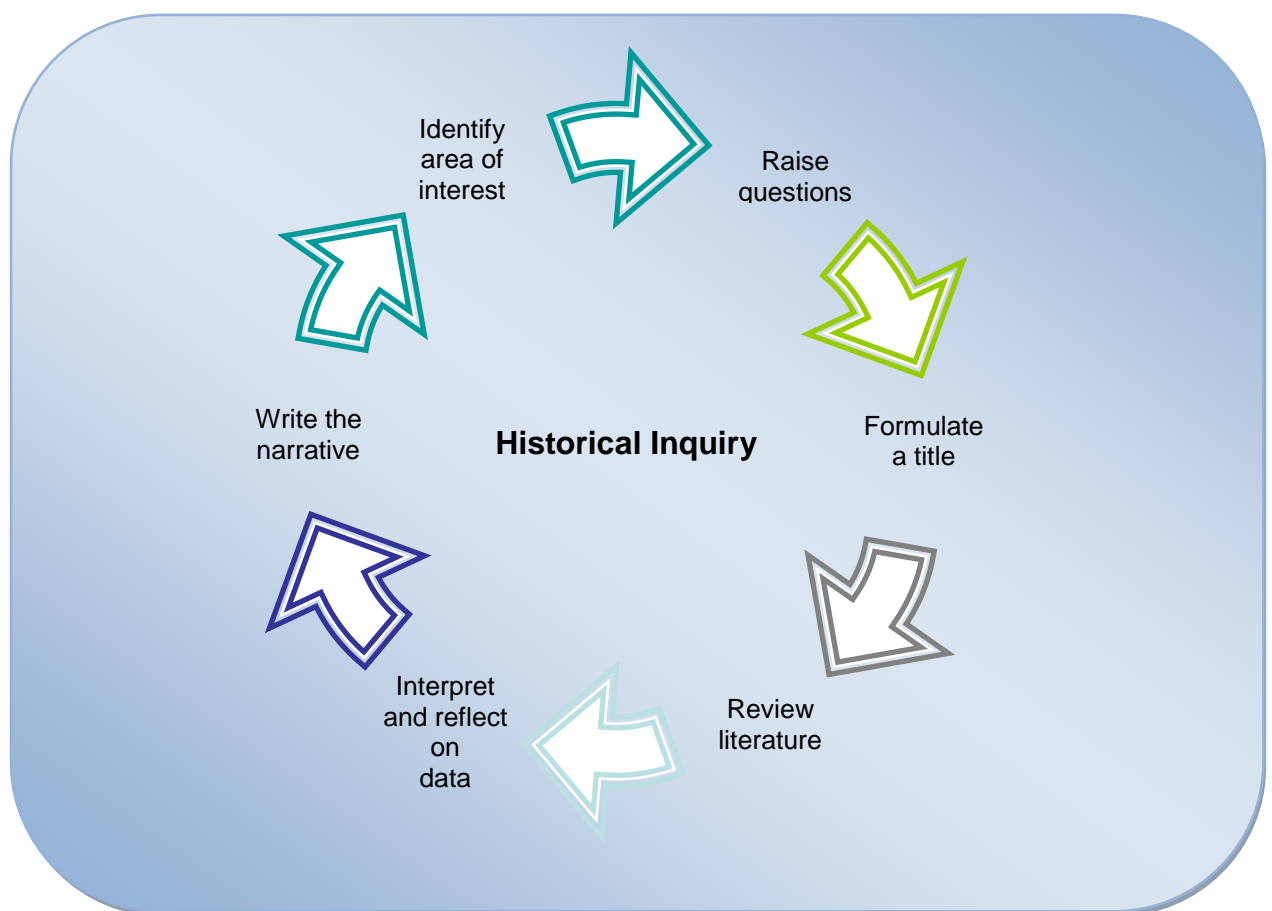


Figure 2.1 Schematic representation of the historical research process

As the figure clearly shows, the process of historical enquiry is cyclical. The double lines indicate that each step of the process will be repeated more than once. Although the historical researcher commences with identifying the area of interest and formulating a working title, the possibility exists that the area of interest and the title of the research might change due to evidence emerging from the literature review and as a result of reflection by the researcher. The historical research process might appear to be straightforward, but novice historians are advised to ask questions throughout the research process and are warned that they must be willing to change the title of their research project many times, which was the case in this research. Peter Novick (Lewenson & Hermann 2008:21) describes the challenge of writing a historical narrative as being similar to “trying to nail jelly to a wall” (Kruman 1985:112; Lewenson & Hermann 2008:21, 31).

The final step in the historical research process entails the analysis, synthesis and explanation of the data. Historical data analysis is a creative process. In this study, the data was sorted into themes and then interpreted within the context and time of the research objectives. The validity of the interpretation was ensured by means of meticulous reference to specific sources in each case. These cases are described in terms of themes and not separate, single units. Thus references were provided once the particular theme has been comprehensively described. To instil methodological discipline into the process of reading and writing, the researcher placed the study into the socio-historical context where most of the nursing history written during the past 20 years was to be found (Brink & Wood 1998:357, 369–370; Lewenson & Hermann 2008:17–18).

Historians emphasise that any interpretation of historical data should take place within the context of the historical period being studied. Failure to do so would result in ‘presentism’: the presumption that people from past generations reacted in the same manner as people do today. Thus historians appear to complicate self-evident issues because they study the dynamic interactions between people and their social environment. By means of reflection, they consider how noteworthy past events were within their historical time and place. Yet, this mental manipulation of events must be performed in a manner that not only explains why they occurred, but also honestly and critically evaluates the significance of these events and the people involved (Brink & Wood 1998:360; Galgano et al 2008:2, 4; Lewenson & Hermann 2008:14–16).

The strengths of historical inquiry lie therein that it gives multiple answers to questions raised about historical events. Not only does it assist in solving nursing-related issues, but owing to the diverse factors (such as economics, culture, politics and social issues) that have an influence on nursing, historical inquiry tends to answer more than only nursing-related research questions (Brink & Wood 1998:362).

However, historical research also has its weaknesses. The researcher's own subjectivity or bias may dictate which historical data is included in or excluded from the study. Barzun and Graf (Kruman 1985:115) describe bias as a form of interest which is inadequately managed by the researcher. The subjectivity of human nature makes it impossible to exclude all forms of bias, but it is important to recognise and control it.

With the aim of recognising and controlling (bracketing) her own biases, the researcher kept a reflective journal and performed an ethical self-assessment after the research objectives had been reached.

Potential weaknesses of historical research relate to the sources. The primary sources (data) available might not be written in the form that the researcher required, and thus he/she must work with inflexible data. The researcher may have limited or no access to the primary data sources, which could hamper the comprehensive analysis of historical events. Finally, historical research can be very expensive and time-consuming to complete as travelling to where the data is stored may be required (Brink & Wood 1998:362; Galgano et al 2008:4). In an attempt to create the complete historical picture, and thus provide context, the researcher's reference to sources rather reflects themes and not single facts.

In an attempt to overcome the aforementioned weaknesses, the researcher provided extensive references, thus affording the reader the opportunity to locate the primary and secondary sources that were used in the study, and to confirm whether or not these sources had been represented within their historical context. Limited access to relevant primary and secondary sources remained problematic, but the modern, electronic availability of historical databases afforded the researcher the opportunity to identify most of the available documents related to the topic.

2.2.1 Research problem

The research problem originated from the researcher's personal experience as a nurse educator. It became evident that most nurse educators and their nursing students did not place much value on nursing history and, in fact, had little knowledge of the topic.

One possible explanation was that the majority of South African nurses did not relate to the history being taught in nursing curricula, because the inclusion of black South African nursing history was rare. To this day, nursing curricula teach mostly European nursing history.

Changes in the South African socio-political landscape necessitated a re-evaluation of the nursing history being taught to nursing students. How much of the history of the development of black South African nurses had actually been recorded? Were there any social, political, cultural or economic factors which influenced the development of black South African nurses? How could this nursing history be included in the teaching and learning of nursing students in a socio-politically new South Africa?

To date, few South African nurse historians have taken up the challenge of analysing and recording the economic, social, political and cultural factors which influenced the development of black South African professional nurses during the period 1908–1994. (Therefore few inclusive sources about the topic are available.) It became evident that not only the European origins of nursing, but also the historical development of black professional nurses in South Africa should be included into the teaching of young nursing students.

2.2.2 Research purpose

The purpose of this study was to explore the nursing literature by means of historical inquiry into the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994 thereby providing guidance in the teaching of an inclusive South African nursing history.

2.2.3 Research objectives

The researcher identified two research objectives. The first objective was to explore the economic, social, political and cultural factors that influenced the development of black South African nurses during the period 1908–1994. The second objective was to document the abovementioned data in order to guide teaching an inclusive South African nursing history.

2.3 RESEARCH METHODS

In the following sections, the research population and sampling techniques are described and the principles of data collection and analysis are discussed.

2.3.1 Population

Before research findings can be generalised, a study sample must be carefully chosen from an identified population. According to Stommel and Wills (2004:297), “the population constitutes the universe of interest”. Such a population may not necessarily refer to people, but to objects that the researcher is interested in studying (Brink et al 2006:123; Maree & Pietersen 2010:170).

Regardless of the type of study being conducted, or the nature of the population, the assertion that the population represents the total field of interest is valid. In a research project of limited scope constrained by a reduced time frame, this *universal population* might not be available to the researcher in its totality. Therefore the researcher must identify and define a specific aspect within this *universe of interest* to study. The act of defining a specific aspect within the context of its universe is referred to as the process of defining the target population (Stommel & Wills 2004:297).

In this study, the researcher was interested in nursing literature which provided information about the social, cultural, political and economic factors that influenced the professional development of black South African nurses. Thus the nursing literature itself was regarded as the target population. However, as the target population was not specific in its description of the dimensions of time and location, it was in fact an infinite population. Therefore the finite, *accessible population* had to be considered – that is,

that part of the population to which the researcher had reasonable access. This accessible population is often described in terms of geographical location, association with an institution, or personal characteristics. It is also defined by the time period which a researcher specifies as the scope of the research.

The researcher studied the nursing literature which provided information about the social, cultural, political and economic factors that influenced the professional development of South African nurses from 1908 to 1994 in order to document an inclusive nursing history for the mentioned period. To ensure that all the relevant nursing literature sources would be accessible and considered during the proposed historical inquiry, the following inclusion criteria, described by Stommel and Wills (2004:297) were applied:

- Documents (primary sources) of historical value and relevant to the research objectives stored at the Democratic Nursing Association of South Africa (DENOSA), the SANC archives, State and University Archives in Gauteng.
- Secondary source documents in the tertiary academic libraries of Gauteng, and access to electronic sources indicated by reputable, scientific, historical online databases.

A limitation in the time available for research and the cost of the project lead researchers to choose a study sample from the identified, accessible population. This process of choosing a section (or part) of the accessible population, which will most probably represent the characteristics of that population in general, is referred to as sampling. An adequate sample ensures that research findings can be generalised, but only if the sample is truly representative of the population. This is especially relevant if the research project is quantitative in nature, whereas in qualitative research the sampling is more flexible and the sample size smaller (Brink et al 2006:124–125; Maree & Pietersen 2010:172; Stommel & Wills 2004:329–331).

It was not the aim of this research to generalise any findings as the developmental history of professional black South African nurses remains unique to them – their history cannot be generalised to a population of black nurses elsewhere in the world.

2.3.2 Sample selection

In general, qualitative research uses a smaller sample of the accessible population than quantitative research. It aims to obtain valuable information that is “context-sensitive”. It is precisely this need for “context-sensitive” information that dictates the use of non-probability sampling techniques in qualitative research projects such as the current study. The random selection technique used in probability sampling will remove the context from the sample and thus the qualitative researcher loses information that should be interpreted within the context it occurred. By contrast, non-probability sampling allows the researcher to include the information-specific historical literature sources which most accurately explain the phenomenon being studied. Non-probability sampling is used in research projects where access to the elements is limited, the population being studied is not modifiable to probability sampling, and where there are issues of cost and convenience (Brink et al 2006:131–132; Maree & Pietersen 2010:176–177; Stommel & Wills 2004:280, 300, 329).

The motivation for the specific inclusion of preferred sources was the reason why the researcher used non-random sampling techniques as no distinct, random selection process was implemented during this historical inquiry. The researcher also considered the possibility that the historical archives available to her might not have contained all the important sources needed to present a comprehensive picture of the phenomenon being studied and, certainly, that the historical literature cannot be modified to suit the requirements of probability sampling. It was these uncertainties regarding access to the sample which validated the researcher’s choice to implement non-probability sampling techniques.

In qualitative research, the focus is on understanding the lived experience of a specific group (element) in the population; therefore it is acceptable that non-probability sampling leads to research findings that are not representative of the population. Historical documents communicate the writer’s intention at the time of writing and contain material that makes it possible to determine what socio-economic and other factors motivated and influenced the author. As a historical document represents the writer’s lived experience, some qualitative researchers argue that generalising the research findings is impossible and less important than generating ample variation.

(Brink et al 2006:131–132; Dempsey & Dempsey 1996:75; Maree & Pietersen 2010:176–177; Stommel & Wills 2004:303, 329).

This dissertation is a representative example in that the findings represent unique descriptions related to black South African nurses' professional history which cannot be generalised to represent the experiences of black nurses elsewhere in the world.

In this historical study, non-probability, purposive sampling was used. Maree and Pietersen (2010:178) describe purposive sampling tersely as “sampling done with a specific purpose in mind”. Nieuwenhuis (2010b:79) states that purposive sampling is most effective if the data review and data analyses are performed simultaneously with the data collection. With the aim of contributing intentionally to the investigation of the phenomenon, the researcher purposely chose a sample with certain characteristics. This substantiates the argument advanced in the previous paragraph that the focus is not on having a sample representative of the population, but rather on understanding and gaining an in-depth knowledge of the phenomenon (in this study, black professional nurses in South Africa) being studied. In this research, the sample size was therefore determined by the quality of the data obtained and data saturation occurred when the phenomenon being studied had been clearly understood and fully explored (Brink et al 2006:136; Stommel & Wills 2004:302). Therefore the researcher's sample size was only known at the end of the research project when data saturation had occurred. As described earlier, the advantages of non-probability purposive sampling techniques allowed the researcher to include all those literary sources that contributed valuable information (data) to the current study.

A definite disadvantage of non-probability sampling is the risk of researcher bias. Such bias is evident when the sample is chosen to reflect the researcher's opinion as opposed to what is factual. For example, the researcher might select and include documents in the sample which reflect only positively (or negatively) on the conduct of a specific ethnic group (Brink et al 2006:126; Stommel & Wills 2004:302).

The researcher avoided this risk by implementing the strict ethical code described in section 2.5 of this chapter, by providing extensive references, and by keeping a reflective journal which ensured bracketing.

2.3.3 Data collection

Historical inquiry is best suited to an unstructured data collection method. The researcher studied the nursing literature that contributed to identifying the economic, social, political and cultural factors that influenced the development of black South African nurses. These influencing factors were studied within the context of the time (1908–1994) in which they occurred, and the researcher did not manipulate data to suit a designated framework. This unobtrusive method of data collection is dominant in the qualitative, naturalistic paradigm (Nieuwenhuis 2010b:78–79). However, in this study, the researcher used *a priori* codes (discussed in sub-section 2.3.4) to provide direction and a certain measure of structure to the data-collection process.

In most qualitative studies, data collection is not a process distinct from data analysis, but rather it is a cyclical process in which the collected data is analysed and reflected upon as was the case in this research. Reflection assisted the researcher in identifying the areas in which more data had to be collected and, in turn, be reflected upon. This cyclical process continued until data saturation occurred and it was especially important to the researcher as it supported the practice of studying relevant nursing literature, reflecting upon it, and identifying which areas (e.g. economic, social, political, cultural) required more reading. In this manner, the researcher herself was the data-collection ‘instrument’ and the in-depth study of the documents made it possible for patterns and trends that occurred over time to be identified (Brink et al 2006:155; Lewenson & Hermann 2008:6; Nieuwenhuis 2010b:79, 81–82).

The use of nursing literature as the population and sample rendered the inclusion of information-rich documents important (Stommel & Wills 2004:302). The researcher remained mindful of Nieuwenhuis’ (2010b:83) argument that, to ensure that historical documents are rich in data as well as historically sound and authentic, a number of issues such as the ones below had to be considered before the document could be included in the study as an importance source:

- The type of document, namely primary or secondary source.
- The publication date of the document, which might have an influence on the interpretation of the document since a historical document must be interpreted within its specific context (Brink & Wood 1998:360; Galgano et al 2008:2).

- Does the foundation of the document stem from empirical data, personal opinion, or is it an anecdotal account?
- What was the context in which it was written? Was it written for any specific purpose?
- What is the main focus of the document and, more importantly: how does it fit in with the proposed research objectives?
- In the case of a document based on empirical data, what research methodology was used?

Lewenson and Hermann (2008:18) add to this list by reminding researchers to consider the author's background and biases as these would have influenced the data recorded in the document.

In a similar fashion, Hargreaves (2008:41) lists four criteria that will dictate the inclusion or exclusion of historical documents in a research project, namely:

- The authenticity of the document: consider whether or not it is a copy or the original document. In the case of hospital records: is it incomplete and difficult to find?
- The credibility of the source: how selective or distorted is the content of the document? The researcher must therefore determine who the author is as well as the reason why the document was created.
- Its representativeness: view the document against the background of the literature related to the historical period. The researcher must ask how the document fits into the framework of all the documents relevant to the subject (which presupposes a thorough reading and understanding of the research topic).
- The meaning of the document: how easy or difficult is it to understand the document? (The meaning of a partially destroyed or not fully translated document might remain hidden.)

Lastly, McDowell (2002:113) advises historians to consider the following issues while reading historical documents:

- Consider the type and origin of the document.
- What is known about the author of the document?
- Did the author participate in the event, or was he/she removed from the event in terms of time or physical proximity?
- Was the author able and willing to state the truth?
- Are there factual errors in the document?
- Is the writing style of the author similar to that of other documents written by the same author? Are there inconsistencies with regard to handwriting, spelling or alterations made?
- Is there more than one version of the same document? If so, why?
- Was the document intended for public or private use?
- In writing the document, did the author gain any personal advantage, e.g. rationalise any mistakes made?

Throughout this research, the abovementioned authors' recommendations were considered by means of a checklist that was compiled by the researcher (see Annexure B). The checklist is a technique of measurement that indicates to the researcher if certain behaviour, in this case characteristic of the historical document and the author, has been observed (Burns & Grove 2009:402).

Although documents can be rich, valuable sources of information concerning the phenomena under study, there is the risk of error if the abovementioned considerations are ignored. The records themselves may contain distorted facts, or even have facts omitted. The researcher also has to consider the fact that some information is private in nature and that disclosure may have ethical consequences (Brink et al 2006:155). Thus, in the case of this research, the ethical code discussed in section 2.5 of this chapter was strictly adhered to.

Erratic recording in historical documents and institutional bias may lead to misinterpretations on the part of the researcher. In order to prevent this misinterpretation of facts, the researcher contextualised her reading of the historical documents within the specific framework of historical inquiry. During the past twenty years, most of the historical writing about nursing was produced from a socio-historical context. It is precisely this contextualisation of the study that provided the researcher

with methodological discipline during the phases of reading, researching and writing. The placement of the study in a social historical context provided structure and guided decisions about the data to be included in the study. It also guided the researcher in decisions regarding the importance of the information (data) found. Therefore the contextualisation of historical inquiry directed the researcher in her judgements (Brink et al 2006:155; Hargreaves 2008:41; Lewenson & Hermann 2008:17–18, 37).

After the research objectives had been formulated, historical analysis required that the researcher identify and read secondary sources related to the historical objectives. The secondary sources assisted in framing and refining the research objectives. It also provided the researcher with valuable background information and added historical context to the events being studied. Historical context was effectively provided by considering all variables that might have influenced the historical events. The inclusion of all variables (in this study: socio-economic, cultural and political factors) provided strength to the historical analysis (Brink & Wood 1998:357; Galgano et al 2008:5; Lewenson & Hermann 2008:13).

2.3.4 Data analysis

Qualitative data analysis derives from interpretative philosophy and aims to draw meaning from the data collected. This approach allows the researcher to identify significant themes, or patterns, in the raw data by using the process of inductive analysis. Inductive reasoning allows the researcher to “develop generalisations from specific observations” (Brink et al 2006:6; Nieuwenhuis 2010a:99; Stommel & Wills 2004:369).

In this study, qualitative data analysis was not a specific, identifiable step in the research process, but rather it was a component of the historical inquiry cycle, namely data gathering, analysis and reflection. The aim was to interpret the data and understand its implications. This required the researcher to use a disciplined, systematic approach, yet to draw on her creativity during the process of recording the research findings. This disciplined, systematic approach was assisted by the rigour of the type of analysis chosen for the research project, namely content analysis, which is used to identify and summarise the “message content” of written documents (Nieuwenhuis 2010a:101). It is an inductive and non-linear process during which the

written text is viewed from different angles in an effort to identify key facts that will assist in the understanding and interpreting of data. It required the researcher to become deeply involved (immersed) in the data (Brink et al 2006:184; Lewenson & Hermann 2008:37; Nieuwenhuis 2010a:100–101).

While analysing data, a researcher has to recognise that, within a given time and place, all the variables interact and therefore cause change. The researcher provides strength to the historical analysis by recognising this fact and by including all the essential variables. Historians “mentally manipulate the effects of the variables within their time and place to judge relative significance.” (Lewenson & Hermann 2008:13). Thus, looking at an issue from a different angle may just reveal which question history is *not* answering (which fits in with the concept of content analysis described earlier).

Currently, nursing history focuses on the challenges faced by European nurses and how they shaped the development of the profession in South Africa. In this dissertation, the focus moved away from European nurses towards the role of black South African nurses: what challenges did they face and how did they shape the history of professional nursing in South Africa?

When performing a content analysis of the data, the qualitative, inductive researcher allows the codes to emerge from the raw data. However, there are occasions where the researcher may decide to use a set of existing codes that emerged from a literature review. This type of coding is referred to as *a priori* codes. It is valuable because it guides the search for appropriate data sources and content (Nieuwenhuis 2010a:107–109). The codes that were used in this dissertation did not emerge from the raw data, but were identified before data collection occurred.

The unpredictable nature of historical inquiry does not allow the researcher to be inflexible with regard to specific sets of *a priori* codes. Rather, the use of *a priori* codes is a practical way of guiding the researcher to collect data methodically. However, during the process of documenting the findings, the nature of the findings might dictate the use of a different set of *a priori* codes, or even abandoning the codes altogether. The researcher must be guided by the data collected and analysed as, ultimately, the findings must be represented accurately and within the historical time frame and perspective.

Prior to commencing the first literature review, the researcher had planned to use *a priori* codes referring to cultural, social, economic and political factors that influenced black nurses' professional development. However, this soon proved to be impractical due to the overlapping nature of history: one cultural factor may be evident throughout the decades, and therefore the use of such codes would lead to repetition and possible loss of other valuable data that does not fit in with the *a priori* codes. By contrast, the use of *a priori* codes in the form of a given time period allowed more flexibility. During data gathering, the time frames assisted in guiding the research, yet they did not force the researcher to exclude any influencing factors that were identified in the primary and secondary sources. As the purpose of the research was to expand South African historical literature and the knowledge currently available to nurse educators and their students, it was important that all factors influencing the development of black South African nurses had to be included in the study. In addition to creating the dedicated time periods, the researcher also named each of these *a priori* codes. In each case, the chosen name depicted a major socio political event which defined the era. During the recording phase of the research, the *a priori* codes provided focus regarding the data to be included in each chapter.

The focus of data analysis is not only to describe *what* happened, but also to view the data within its given time and find the data that explains *why* it happened. Therefore the researcher studied the interaction between people, politics and everyday practice. A critical analysis of the historical importance of events and persons and a judgement and direct statement about it were made. In this regard, the researcher was guided by using questions regarding historical context posed by experienced historians.

To read literature for the historical context, Galgano et al (2008:42) suggest that the researcher should ask the following questions:

- Who are the most important participants in the event?
- How did they respond?
- What factors conditioned this response?
- What are their values and beliefs? Are they in tune with others of the same time?
- What were the economic, political, social and cultural systems of the time?

- To what extent are ethnicity, gender and class important?
- What were the major historical forces at work during that time?
- How did these forces affect different groups?

2.4 DESIGN VALIDITY

Owing to the qualitative, non-traditional nature of historical inquiry, the researcher made no effort to control the research setting or data. The purpose of the research was to gain a clearer understanding of the social, economic, political and cultural factors which influenced the professional development of black South African nurses during the period 1908–1994. An in-depth exploration of the relevant research literature assisted the researcher in developing a clearer understanding of how events from the past influence current and future events.

The interpretation of historical data is always influenced by the researcher's opinions, and therefore a certain measure of subjectivity is inevitable. In an effort to remove or at least limit these influences, a hermeneutic approach to the research project was chosen. It is an interpretive approach which guides the reader through three phases of data interpretation, namely *naïve reading* (the reader starts to form thoughts about the meaning of the data), *structural analysis* (also called interpretive reading) and, lastly, the *interpretation as a whole*. This last step of the process requires the reader to reflect on the data and come to a conclusion as to its meaning. Thus a "circle of understanding" is created where "the reader's prejudices are brought to the text and are repeatedly remodelled as the reading progresses". Such an approach removes threats to rigour and ensures accuracy of sources and quality of interpretation. It allows synthesis of the author's view with that of the person interpreting it (Lewenson & Hermann 2008:154–155; Streubert Speziale & Carpenter 2003:63–64).

During the interpretation of the historical data, the researcher used these methods of reading to reflect consciously on the raw data and consider the purpose of the research in order to give nurse educators and students insight into how nurses and nurse leaders from previous generations made sense of their situation.

Unlike quantitative research, qualitative studies are more intuitive and creative in nature. Therefore validity or rigour cannot be strictly applied in qualitative studies; yet

the need to ensure credible results is essential. The terms *validity* and *reliability* are closely associated with quantitative research; not qualitative research. The use of the term *validity* in qualitative studies is an ongoing debate, with no less than five stated positions. Supporters of the replication perspective state that validity is essential in both qualitative and quantitative studies, but qualitative research requires different methods to achieve it. Lincoln and Guba (Polit & Beck 2008:537) support a parallel perspective, arguing that qualitative research requires a totally separate set of evaluation criteria; therefore, they have developed the principles of trustworthiness. Some researchers state that there is no commonality between qualitative and quantitative research and that standards of validity (as used in quantitative research) therefore do not apply to qualitative research at all. Others have abandoned the principle of validity in total (the “letting-go-of-validity” perspective). Finally there are those who state that the set of standards should suit the type of qualitative study being conducted (Cutcliffe & McKenna 1999:375; Polit & Beck 2008:536–538).

In this study, the researcher has adopted Lincoln and Guba’s parallel perspective and used their framework to establish trustworthiness. Lincoln and Guba identified five techniques that may assist the qualitative researcher in ensuring trustworthiness or rigour (Brink et al 2006:118; Cutcliffe & McKenna 1999:377; Nieuwenhuis 2010b:80; Polit & Beck 2008:539; Streubert Speziale & Carpenter 2003:38):

- *Credibility* refers to the confidence that one has in the truth value of the researcher’s data interpretation. This can be achieved by immersing oneself in the data and, if possible, allowing participants in events to evaluate the accuracy and truth of the findings.
- *Dependability* of the research results can only be achieved if credibility has been established. In this study, the researcher had to ask herself how sound and reliable her findings were.
- *Confirmability* allows the researcher’s findings to be confirmed by two or more other persons. However, Sandelowski (in Streubert Speziale & Carpenter 2003:39) states that this might not be possible as only the person who has immersed him-/herself in the subject is able to confirm the findings. In this study, the researcher laid an audit trail by means of extensive referencing and a reflective journal (note Annexure D). These techniques allow fellow researchers to confirm the findings of this study by studying the primary and secondary

sources themselves. This also ensured that the researcher's biases were excluded from the findings as much as possible.

- *Transferability* addresses the potential generalisation of research findings. Owing to the historical nature of this study and the focus on one particular profession during a defined period of time, transferability was not possible in this study despite the richness of the data. However, because of the audit trail replication was possible.
- *Authenticity* provides context to the research findings. The narrative written at the end of the study should provide a sense of the lives of the people involved: their language, habits and lived experiences. The researcher used examples from literature, films and biographies to illustrate the environment in which her subjects lived and worked.

Questions regarding validity are answered by external criticism while questions regarding reliability are determined by internal criticism (Brink et al 2006:111; Brink & Wood 1998:370; Burns & Grove 2009:537–538; Dempsey & Dempsey 1996:89).

In historical inquiry, external criticism (validity of data) refers to the authenticity of the primary and secondary sources used, while internal criticism (reliability of data) answers questions about the accuracy, meaning and credibility of the document's content. In this study, the researcher was guided by a checklist of criteria for including historical documents in the research project (see Annexure B). To confirm the credibility of the source, the researcher would search for and find corroborating evidence which assisted her in giving context-rich descriptions. This ensured that the researcher's interpretations of the relevant historical events were as accurate (credible) as possible and not influenced by biases. At the end of the research project, the researcher asked and answered the question: "Do the findings represent reality?" The answer to the question relates to validity (external criticism) (Brink et al 2006:111; Brink & Wood 1998:367–368; Burns & Grove 2009:537–538; Kruman 1985:73; Phelps, Sadoff, Warburton & Ferrara 2005:225).

In determining the external validity of a historical document, Phelps et al (2005:225) suggest that the following questions must be answered:

- What was the original location of the document? Where is it now?
- Does the document prove to be the original, or a copy? If it is a copy, where is the original?
- Consider the approximate age of the document.
- Does the document contain any autographs or notes that may assist in the process of verification?
- In case of a handwritten document, is the handwriting similar to that in the other known works of the same author?
- Are there any references in other documents to validate this document's existence?
- Are there reasons to suspect that the document may be fraudulent?

Phelps et al (2005:230–231) furthermore suggest asking the following questions in order to establish the internal validity of a historical document (these considerations were included in the researcher's check list of criteria for inclusion of historical documents):

- In comparison to other documents by the same author: are there any major inconsistencies in the literary style?
- Are there any reasons to suspect that the author recorded the events inaccurately?
- Does the author mean what is being said? (The author might have made a semantic error.)
- Did another author write the document, using the style of the author in question?
- Does the document provide evidence of bias or prejudice?

Qualitative researchers state that there are multiple realities in life. Therefore, if a primary or secondary source reveals data or opinions different from those of other sources, it is not regarded as incorrect or detrimental to the study. Rather it is viewed as a unique reality in a world filled with different realities. After all, reality is said to be how people view events. Crystallisation allows the researcher to view the different facets of a complex historical event, and it is only a deeper understanding of all the views regarding the phenomenon that makes it possible for a deeper insight into the

nature of the phenomenon to emerge (Nieuwenhuis 2010b:81). In this study, the researcher obtained crystallisation by including all the factors (socio-economic, cultural and political) which might have influenced the development of black South African nurses. Irrespective of the researcher's preferences and biases, all primary and secondary sources had an equal opportunity to be included in the proposed study.

Qualitative researchers prefer terms such as *transferability* or *fittingness* to describe the quantitative term *external validity*. Some qualitative researchers state that qualitative studies are written narratives and that a measure of intuitive deduction from the data is implied. This leaves the readers of the narrative to draw their own conclusions from the story. However, this creative component of qualitative research does not give the researcher a licence to make up a story as she goes along. Rather, it emphasises the responsibility of accurate and responsible representation of (historical) data (Cutcliffe & McKenna 1999:376).

By providing a comprehensive description of events, the researcher enabled fellow researchers to determine how applicable or fitting the research findings were to the setting in question, as well as how transferrable the findings were to other settings.

2.5 ETHICAL CONSIDERATIONS

Galgano et al (2008:13) argues that questions regarding social history almost always raise questions about a particular society's political beliefs. In this study, the interpretation of the historical events which occurred during a volatile South African socio-political era might have been influenced by the researcher's own views and ideologies. Thus the importance of including all the possible variables and using reflection to bracket one's experiences and beliefs was essential. Several authors, such as Husserl and Ashworth (in Cutcliffe & McKenna 1999:377) state that credibility of research findings are enhanced if the researcher first acknowledges his/her own presumptions and perceptions.

The researcher's bracketing of own biases ensured an essentially truthful interpretation of historical events. By means of crystallisation, the researcher aimed to accurately represent the factors that influenced the development of black South African nurses during the period 1908–1994.

Although the views and policies of the social, cultural, economic and political institutions involved (such as political parties and South African nursing institutions) must be presented in their historical context, the researcher was sensitive to the memory and views of persons (alive or deceased) who were part of the era 1908–1994. The research was conducted in accordance with the standard of professional conduct for historical inquiry in nursing described in Lewenson and Hermann (2008:170–72), and personal judgements on historical events or presenting historical figures and events subjectively to suit a personal agenda were avoided. In this study, the researcher reviewed her reflective narrative for evidence of bias or judgement on historical events. In addition, she also signed a declaration (see Annexure C) to confirm her observance of the standards of ethical conduct.

The researcher supported the code of ethics published by the American Association for the History of Nursing (AAHN) in the Spring 1993 edition of the Bulletin, which refers to issues related to the historian's relationship to sources, subjects, community, colleagues, students and the canons of history (Lewenson & Hermann 2008:169–172). The issues of special importance to the researcher were the following comments on the work and responsibilities of the historian who:

- has the responsibility to the sources of accurately presenting all the facts related to the topic
- has the responsibility to represent the historical truth as far as she is able to find it in the sources available to her
- values and acknowledges the work done by others
- acts as advocate to promote the preservation of historical sources
- fosters appreciation for history in schools and the community at large
- presents history in a responsible manner
- is dedicated to the truth and thus rejects any misrepresentation of historical events as unprofessional
- actively strives to increase awareness and appreciation for the history of nursing
- communicates her historical research findings

- shares information and sources with colleagues in order to promote historical research
- supports the inclusion of historical topics in nursing conferences
- promotes student participation in historical inquiry projects
- recognises the effect of biases on recorded history
- applies academic honesty when analysing and interpreting historical data
- uses relevant historical research methodology
- recognises that historical research creates a golden thread between the present, the past and the future
- applies the views of Lewenson and Hermann (2008:172) by avoiding any form of plagiarism, not tainting the reputations of other persons, not damaging or destroying historical records and not refusing reasonable requests from fellow historians to provide them with resources

The researcher adhered to the mentioned ethical code by providing textual references, and an extensive resource list. By using a reflective diary, the researcher practised bracketing and in this manner limited her (potentially) biased influence on the representation of the historical data. In addition, by completing the self-evaluation check-list recorded as Annexure C at the end of the research project, the researcher confirmed her observance of the ethical code. Fellow historians have access to the documents used in order for them to verify the correctness of this researcher's analysis. The extensive acknowledgement of sources also served to prevent issues of plagiarism.

2.6 CONCLUSION

By means of historical inquiry, the researcher explored the social, political, economic and cultural factors that influenced the development of black South African nurses during the period 1908–1994. The research project was qualitative in nature, with nursing literature as its population and sample.

The researcher ensured that the historical truth was recorded by only including those historical sources which provided context-specific information. Although an unstructured data-collection method was used, a checklist had been designed which

assisted the researcher in including only authentic historical documents. This checklist also assisted in promoting internal and external validity. Finally, data analysis was performed by means of *a priori* codes to provide structure to the study.

Biases were limited as much as possible insofar as the researcher kept a reflective journal and, at the end of the study, completed a self-evaluation checklist to ensure that the study complied with the ethical code discussed in this chapter.

CHAPTER 3

NURSING UNDER THE CONTROL OF THE MEDICAL COUNCILS 1908–1944

George Banks: *"I suggest you have this piano repaired. When I sit down to an instrument, I like to have it in tune".*

Mrs Banks: *"But, George, you don't play".*

George Banks: *"Madam, that is entirely beside the point!"*

(Quote from the 1964 musical: "Mary Poppins").

3.1 INTRODUCTION

In the year 1892, South Africa had 49 trained nurses – none of them black. This number, in the form of registered nurses and midwives, increased tenfold between 1933 and 2006 (Breier et al 2009:16). The 1990 count of registered, enrolled and auxiliary nurses in South Africa (excluding those working in apartheid's 'homelands') indicated an approximate number of 150 000. Of this number, only a third was white, with two-thirds of South African nurses being black and coloured persons. In the African community, this number of professional, mostly female, nurses was greater than the combined number of male professionals and semi-professionals. This begs the question which circumstances led to this increase in numbers within the relatively short period of 98 years (Breier et al 2009:16; Marks 1994:1).

To date, the history of South African nursing has focused mainly on the role played by white European nurses. Although their contribution to the development of professional nursing in South Africa cannot be denied, there is a definite need to focus on the development of nursing from the viewpoint of black African nurses. What were the social, economic, political and educational influences that contributed to, or hampered, their entry into nursing and their subsequent development into one of the largest professional groups in South Africa? (Buthelezi 2004:1; Marks 1994:2; Mortimer & McGann 2005:2, 9).

In this chapter, the social, economic, political and educational factors that influenced the development of black professional nurses in the *a priori* period 1908–1944 are discussed. The discussion covers the time during which South African nursing was

established and supervised by English nurses but ultimately controlled, not by nurses, but by the colonial medical councils. The time-frame chosen commences with the registration of the first black professional nurse (Cecilia Makiwane) in January 1908. It ends with the founding of the nursing profession's own controlling body, the SANC, on 20 June 1944 in terms of Nursing Act no. 45 of 1944 (Marks 1994:123; Searle 1991:97; South Africa 1944). Diagrammatically this development can be represented as follows:

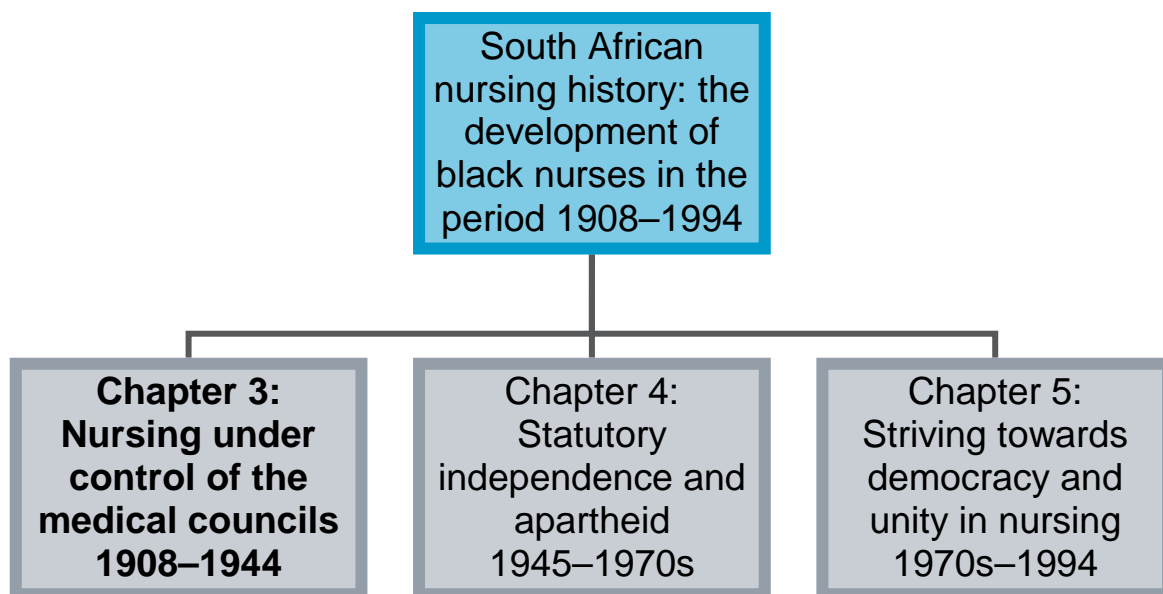


Figure 3.1 Schematic representation of the *a priori* periods discussed in this dissertation

(The period discussed in this chapter is represented in bold.)

3.2 HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER

In an effort to identify the economic, socio-political and cultural factors which influenced the development of black South African nurses, the researcher decided to use the literature sources that provided the most valuable and context-specific information. This included South African general history books, history books specific to nursing, South African Acts, minutes of meetings found in archives, and original newspaper reports found in online databases. To illustrate the European social perceptions and beliefs of this period (1908–1944) and the manner in which they influenced the nature and characteristics of South African nursing, classical English literature was occasionally used. Wherever possible, primary sources were accessed to confirm or

refute the description of events provided by the secondary sources. This contributed to the trustworthiness of the chapter (Nieuwenhuis 2010:74).

In the course of the research on which this chapter is based, quotations from primary sources were occasionally used to confirm the views evident in the secondary sources. At times this posed an ethical problem as some primary sources used terminology with reference to African people which modern society considers derogatory. Thus in the time period 1908–1944, newspapers and minutes of meetings often refer to “native” or “Bantu” nurses. In the interests of historical authenticity and accuracy, the researcher retained these words if used in a primary source. In all the other explanations and discussions, the researcher continued to use the descriptors “African” or “black”. A summary of the topics discussed in this chapter is presented clockwise in figure 3.2.

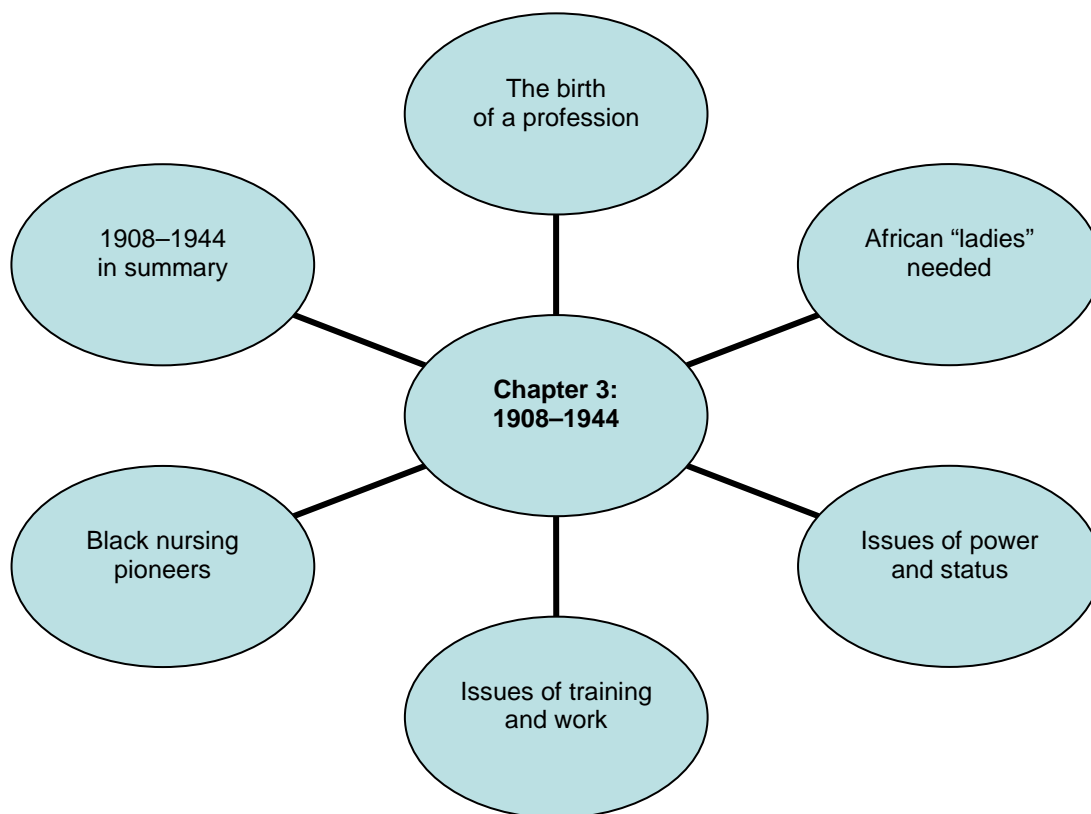


Figure 3.2 Schematic representation of the topics discussed in the *a priori* period
1908–1944

3.3 THE BIRTH OF A PROFESSION

The impressive contributions to nursing and nursing leadership in South Africa made by Florence Nightingale and Henrietta Stockdale are well-documented; hence, a detailed discussion of their achievements within the scope of this dissertation would be unnecessary. However, as the history of nursing as a professional occupation for black nurses does commence with these English pioneers, a brief description of the British influence on South African nursing is called for.

3.3.1 Nursing history before 1908: the British influence

Searle (1991:6) explains that an occupational group must organise itself into a form of authority. This gives social status and political influence to the members of the group to achieve their objectives. The first group to organise themselves in this manner were the British doctors who established the British Medical Association in 1832 which, with the promulgation of the Medical Act of 1858, became a registered profession. Belonging to a profession meant that those registered had prestige and were able to rise to higher posts. It also meant that the profession became a closed profession; thus, unregistered persons were not allowed to practise.

The organising of British doctors into a profession led to other occupational groups following suit and, in 1887, under the leadership of Mrs Ethel Gordon Bedford Fenwick, the British Nurses Association was formed. It was the first female professional association in the world. The association had a branch in Kimberley, where Henrietta Stockdale, as a member of the Anglican Sisterhood of St Michael, had been working as a district nurse and midwife since 1876 (Searle 1991:11–17, 19; Sweet 2004:179).

3.3.2 Voluntary registration status for South African professional nurses

It was in Kimberley, at the Carnarvon Hospital, that Henrietta Stockdale started professional nursing training in South Africa by implementing a formal training programme for nurses in 1877, shortly after completing her own training in London. She actively campaigned for state registration for nurses and, with the support of the doctors she worked with, succeeded in her objective. The Cape Parliament passed legislation which, under the Medical and Pharmacy Act of 1891, made provision for the

voluntary registration of nurses. Thus, nurses in the Cape Colony became the first in the world to obtain registration status. Similar legislation regarding registration for nurses was implemented in the Free State (1893), Natal (1899) and Transvaal (1904) (Searle 1991:6–19; Stevenson 2007:2–3).

It should be borne in mind that, at this time, South Africa was not the united country we know today. Instead there were two colonies under British rule (Natal and the Cape Colony) and two independent states, also referred to as the Boer republics (Transvaal and the Orange Free State). The two Boer republics engaged in a war that was mainly driven by economics; that is, the discovery of gold on the Witwatersrand. The war lasted from 1899 to 1902. This explains the reason for the different dates regarding nursing registration as each area managed its affairs independently from the others. It is noteworthy that the Transvaal (in general, present-day Gauteng, North West Province, Limpopo and Mpumalanga) implemented nursing registration only after the second Anglo-Boer War, when they came under British Imperial rule. Spies (1993:3–31) provides a comprehensive description of the war in *South Africa in the 20th Century*.

Interestingly, state registration for nurses in England occurred only in 1919, mainly due to great opposition in Britain to the idea. Florence Nightingale herself opposed registration and stated that the vocational nature of nursing was of greater importance than the need for scientifically minded nurses as professed by Mrs Bedford Fenwick (Searle 1991:24–26).

3.3.3 The Victorian family structure: its influence on nursing

Marks (1994:4) states that later generations of nurses viewed white nurse leaders such as Henrietta Stockdale as being powerful. Yet, their power was only relative to how much power their menfolk allowed them. The apparent success of nurses' early registration in South Africa was dependent on support from the male, medical doctors Henrietta Stockdale worked with. In nineteenth-century Britain, the relationship between doctors and nurses was based on the power relationships in the typical Victorian family: the father (doctor; male) was the decision-maker; the mother (nurse; female) was the caretaker; and the child (patient) was obedient. This relationship structure is accurately portrayed in the following extract from the 1964 musical *Mary Poppins* (The Internet Movie Database 2011):

Mr Banks: *I feel a surge of deep satisfaction, much as a king astride his noble steed - thank you. When I return from daily strife, to hearth and wife ... How pleasant is the life I lead!*

Mrs Banks: *Dear, it's about the children ...*

Mr Banks: *Yes, yes, yes. I run my home precisely on schedule. At 6:01, I march through my door. My slippers, sherry, and pipe are due at 6:02. Consistent is the life I lead!*

Mrs Banks: *George, they're missing!*

Mr Banks: *Splendid, splendid. It's grand to be an Englishman in 1910! King Edward's on the throne, it's the age of men! I'm the lord of my castle, the sovereign, the liege! I treat my subjects, servants, children, wife [sic] with a firm but gentle hand, noblesse oblige. It's 6:03, and the heirs to my dominion are scrubbed and tubbed, and added, quickly fed. And so I'll pat them on the head, and send them off to bed. Ah, lordly is the life I lead! Winifred, where are the children?*

Mrs Banks: *They're not here, dear.*

Mr Banks: *What? Well, of course they're here! Where else would they be?*

These Victorian divisions related to gender led to (female) nurses being subservient to (male) doctors. This power relationship was not restricted to nineteenth-century hospitals only. According to Marks (1994:4), this dominance of male doctors over female nurses was evident in hospitals as late as the 1940s. In the researcher's experience, it is still evident today but to a lesser extent.

The Victorian-styled power relationships were brought to South Africa and here received another element. Not only was there division based on gender, but British society had a very distinct class system based on wealth and education, which in South Africa soon turned into racial differentiation. From the European perspective, African people in general were not wealthy, nor formally educated. Therefore black people were automatically regarded as being from a lower class and thus expected to be subservient. The European women who came to South Africa were, however, soon faced with a social hierarchy and culture very different from their own – especially with regard to issues of femininity, sexuality and race (Marks 1994:4; Schultheiss 2010:152; Sweet 2004:179).

3.3.4 Religion and the image of nursing

Helmstadter (2009:133-34) states that the “boundaries between medicine, religion, nursing and domestic service were fluid in mid-nineteenth-century Britain”. The traditional role of nurses also encompassed being a domestic worker at the same time. In this respect, the Anglican nurses differed because they were educated women who strived to change nursing into a profession. In the time of the Crimean War (1854–1856), one of the major political issues in Britain was religion. The major social issue was the concept that women should remain at home – they were not supposed to work. In fact, a nineteenth century lady was defined as a “woman with a certain degree of culture who did not work for a living or earn money in any way” (Helmstadter 2009:135). The Anglican nurses challenged both the political and social issues so that by 1856 the question was where nurses and professional nursing fitted into society.

3.3.4.1 *Sister Henrietta Stockdale: religious and a lady*

Henrietta Stockdale was one of a group of white European women who relocated to Africa with the aim of spreading Florence Nightingale’s ideals of nursing and sanitary reform throughout the British Empire. The religious (Roman Catholic and Protestant) sisterhoods played a major role in this drive, and Sister Henrietta herself belonged to the Fellowship of St Michael and All Angels. It is from these religious sisterhoods and Florence Nightingale herself that nursing inherited its notions of duty, ideals of service, and the belief that care of the patient and control of staff should be performed by a “lady”. Henrietta Stockdale had completed her nursing training in 1877 at the University College Hospital established in 1826. It was one of twelve training hospitals in London (Bostridge 2008:94; Mortimer & McGann 2005:110; NHS Foundation Trust [S.a.]; Potgieter 1992:18; 129, 132; Sweet 2004:178).

Before Florence Nightingale’s time, nursing was performed by uneducated women who were notorious for their drunken behaviour. On the first page of his book *Oliver Twist*, the British author, Charles Dickens (1992:3), describes the nurse of the time as “... a pauper old woman, who was rendered rather misty by an unwonted allowance of beer ...”. It was therefore imperative that the image of nursing should change. What better way to do it than by attracting women from the higher, educated class? Not only did

these women have a better education, but they were also expected to assist in the drive to reform nursing into a career suitable to higher-class women. Florence Nightingale placed great emphasis on the need to develop the nurse's character and spirit. Her ideal of a "lady nurse" led to distinct class divisions among English nurses: nurse probationers had an average educational background, while lady probationers were from the higher social classes. Henrietta Stockdale herself came from the educated class of English society: she had received instruction in English literature, Latin, Greek, mathematics and music (Potgieter 1992:16–18, 131; Sweet 2004:181–182).

In line with this objective of improving the image of nursing, the nursing training presented by Henrietta Stockdale in Kimberley was for educated, refined women only. Therefore, she had very Eurocentric; 'Florence Nightingale' views of what the ideal nurse should be like. She chose nursing candidates who were able to read and write, do mathematics and who were able to play a musical instrument. Furthermore, the candidates had to have a workable knowledge of Latin. Certainly, few black African or white Afrikaner woman could measure up to her reputedly very British view of 'a lady'. The first suitably educated Afrikaner woman to train under the watchful eye of Sister Henrietta Stockdale commenced her training in 1886 (nine years after Stockdale had implemented nursing training in Kimberley). The more menial tasks in the hospital wards were performed by black servants, while the nursing was done by the white, English, educated nurses. Though Miss Stockdale believed in the ethical importance of nursing black persons in need of care, she never considered training black persons as nurses. In fact, although there was a Dr Fitzgerald who trained African women in the 1860s to nurse his African patients in King William's Town, formal nursing training for black persons only started in 1903. Thus, even in the early days of the nursing profession in South Africa, there was evidence of a hierarchy based on race and class with the white, European, trained nurses in control and the untrained, black persons performing the more menial tasks in the hospitals (Buthelezi 2004:3; Marks 1994:31–32, 44; Mashaba 1985:ii; Mortimer & McGann 2005:110; Potgieter 1992:132–134; Sweet & Digby 2005:110).

3.4 EDUCATED AFRICAN “LADIES” NEEDED

When the Union of South Africa was established in 1910, all four colonies were still using the Nightingale system of nursing training and therefore the selection of candidates matched the system. The British objective of improving the status of nursing by attracting educated “ladies” to the fold made it difficult for non-British persons to enter the profession – more so for African people, who had a unique, very different cultural and educational background. Against the background of the researcher’s newly discovered awareness of the social and educational barriers that existed for black women in nineteenth-century South Africa, Cecilia Makiwane and her contemporaries’ achievement of registration was remarkable and unique. Cecilia Makiwane not only became the first so-called non-European woman to register as a nurse in South Africa, but also in Africa – and possibly worldwide. At the time of her registration, the only other non-European women who were training as nurses were Maori women in New Zealand (South African Information Service 1961:11–12).

3.4.1 European and African health care systems in the early twentieth century

The traditional Dutch and British (European) health care systems consisted of midwives and the women in the home caring for sick family members by using folk remedies, herbal and patented medication. In comparison, the traditional African health care system focused on indigenous practitioners such as traditional childbirth attendants, traditional healers, sangomas (senior traditional healers or diviners) and “wise women”. Family members took care of the sick. In addition to the caring role women from both cultures had, they were also expected to comply with the domestic, reproductive and economic demands of family life. However, this is where the similarities end (Mortimer & McGann 2005:5, 109; Sweet 2004:178).

The English women who came to South Africa to introduce professional nursing belonged to religious sisterhoods; thus, they were unmarried because they had pledged celibacy and accepted a separation from family life. It must be remembered that nineteenth-century European women, like their African counterparts, were very much expected to remain at home and perform their domestic role. However, with the protection of the church and by voluntarily ‘abdicating’ their traditional female role, strong-minded, educated women could enter the only career available to them: nursing

in the religious sisterhoods. Their decision to join religious sisterhoods gave them the right to self-development, freedom from married women's domestic responsibilities, and the time to excel in their chosen career (Marks 1994:86–88; Searle 1987:21).

This freedom from domestic responsibilities, with sufficient time to excel in a career, was not a luxury afforded to nineteenth-century African women. They were expected to marry and contribute to the economic welfare of the family by performing the agricultural duties of planting and harvesting the domestic crops. This created a barrier for the entry of black women into professional nursing: married women could not leave their homes to go and work in a hospital because they were the primary agricultural producers. Yet, nor could the younger women: culturally, nursing was considered unsuitable for unmarried black women. To add to the conundrum, the European nurses only allowed unmarried women (such as themselves) to train as nurses. The parents of young women, black and white, were also concerned about sending their daughters away from home for training. This situation changed only in the 1920s when the westernised African elite started to view nursing as a prestigious career for women – for example, Cecilia Makiwane's father was a Presbyterian minister (Buthelezi 2004:26; Marks 1994:83, 86–88; Sweet 2004:179).

3.4.2 Entering an European-styled health care system with an African educational background

A major barrier to the entry of black women into professional nursing was their lack of formal, westernised education and the cultural and political reasons discussed in this section.

In the early nineteenth century, few black people valued formal education, because it was a culturally unknown concept. In general, parents were not actively involved in their children's formal education, which explains (according to some authors) why the few black children who did go to school performed badly compared with their white counterparts. Also, the majority of black children who attended school in the period 1900–1943 were male. This did not bode well for nursing: men were not considered by the British missionary training hospitals for nursing training and therefore the majority of black educated children were excluded from the profession. This meant that a very small pool of black educated women were available for nursing training; especially if

the educational entry level (as set by Henrietta Stockdale and the Victoria Hospital) is taken into consideration (Baloyi 2004:63; Mashaba 1995:26).

The greatest educational barrier however, was not parental involvement or males being given preference, but rather the state of formal education for black youth in South Africa. Cultural barriers to entering nursing exacerbated the existing educational barriers. These cultural barriers are discussed in sub-section 3.4.4 of this chapter.

3.4.3 The state of formal black education in the former Union of South Africa

Prior to 1910, there were no government schools for black children and therefore the only access to education was by means of attending mission schools. These schools were few and far between, and only a small number of children had access to them. In addition to this limited availability, as previously stated, was the fact that educating boys was given priority over educating girls. When Cecilia Makiwane registered as a professional nurse with the Cape Colonial Medical Council in 1908, only 6% of African women could read and write. Makiwane herself had had nine years of schooling (Standard VI plus the T3 educational certificate) and therefore she had the recommended education to complete the three-year nursing course presented at Victoria Hospital in Lovedale. The suitability of nursing candidates was considered in terms of their level of school education. Those with 9–10 years of education were considered the most suitable (Baloyi 2004:44; Breier et al 2009:15; Mashaba 1995:12; Searle 1972:270–271).

3.4.3.1 *Black schools in the former Union of South Africa: issues of cost and accessibility*

The *Union of South Africa Act* no. 9 of 1909 addressed the issue of education, albeit ineffectively. It is interesting to note that the educational system already contained racially separated schools by the time the South African Union was formed in 1910. The unification of the four South African colonies by the British was undertaken for political, military and economic reasons. Formally, there were now government and mission schools for black children, but in reality black schools received little state attention until 1935. Black education was neither compulsory nor free as in white schools – a situation which continued until 1947.

As from 1925, black people paid tax, and one-fifth of this “general poll tax” went into a fund for black education. If the tax was not paid (e.g. during the 1929–1934 economic depression), there was no money for education. Therefore black schools were underfunded with little access to resources such as textbooks, classrooms and qualified teachers. There were an insufficient number of schools to address the population’s educational needs: 70% of black children could not be accommodated in schools. The 1921 census counted 4,7 million black people in South Africa. Yet, by 1924 there were only 753 black children in high schools and 78% of 7–14-year-olds did not attend formal schools. (In comparison, 13% of white children attended state-funded schools and this number increased to 19% in 1947.) By the 1930s, 30% of black teachers were in fact unqualified due to the lack of teacher training colleges. Discussions regarding university training for black students had started in 1916 and some black students were allowed to attend the School of Mines (University of Witwatersrand) and the University of Cape Town. The South African Native College, with a total of 20 students, was established at Fort Hare in 1916. Thus the rate of teacher training did not match the educational needs of the black population. To make matters more difficult, the language of instruction was English due to the greater involvement of the mission schools in black education. English was also introduced in state schools by Lord Milner after the British had won the second Anglo-Boer War of 1899–1902 (Baloyi 2004:44, 50–57, 65–70, 70–80, 83; Brits 1993:195, 216; Spies 1993:44–45, 123, 212).

Baloyi (2004:62) and Mashaba (1995:21) state that literacy among black people did improve during the years of the South African Union, yet it is evident that the overall lack of school education influenced the tertiary education of black people in South Africa as few would have been able to make a success of their studies. As late as 1931, no black nursing candidates possessed a Standard IX (Grade 11) or X (Grade 12) certificate. By 1941, 12% had Standard IX and only 4% had passed Standard X (Mashaba 1995:21).

3.4.3.2 The influence of black school education on the development of black professional nurses in the former Union of South Africa

Buthelezi (2004:20) acidly remarks on the lack of state involvement in the training of black nurses by referring to the “Department of (mal-) Administration and (non-) Development”. She states that a lack of access to libraries and knowledgeable persons hampered the academic development of black nurses. This educational state of affairs contributes to explaining the lengthy periods between the registration of the first black woman, Cecilia Makiwane, in January 1908 and subsequent registrations. The second black woman to register was Agnes Boniswa Kakaza in 1915 and then, only four years later, the third black woman, Violet Dongo, registered as a nurse. These women received their training at the Victoria mission hospital in Lovedale, established in 1898. Registration for black male nurses had to wait until April 1931, when the first black male, Ramosolo Paul Tsae, a school teacher, passed the Medical Council examination. Mashaba (1985:641) refers to the period 1900–1944 as the experimental stage of training black nurses, driven by social needs and development rather than by a pre-determined national plan. This lack of a predetermined plan might partially be explained by the fact that the first South African Union cabinet had no Minister of Health (or equivalent portfolio). Searle (1991:98) explains that the slow progress in training African nurses was due to the “shortage of suitable candidates”. Seen against the background of ineffective education and training conditions for black people at the time, it certainly rings true. To add insult to injury, the most suitable candidates were recruited into the teaching profession – not nursing. In 1910, there was only one black professional nurse (Cecilia Makiwane) registered with the Cape Colonial Medical Council, while there were 3 446 primary-school teachers. Given the state of black education, the need for trained teachers was evident, although unfortunate for the nursing profession: by 1937, 255 African nurses were in training nationwide, and by the 1940s there were only approximately 800 registered black nurses in South Africa (Gaitskell 1982:17–18; Horwitz 2007:132; Marks 1994:8; Mashaba 1985:650; Mashaba 1995:27; Mortimer & McGann 2005:110; Searle 1972:271; Searle 1991:97; Spies 1993:52; Sweet 2004:179–180).

3.4.4 The cultural and social divide

Culturally, African women were expected to remain at home as the primary care givers (note discussion in sub-section 3.4.1 of this chapter). This traditional arrangement was still evident as recently as 1968. Professor TG Mashaba states that she experienced opposition from her husband's family when she planned to leave home in order to enrol for the Tutors' Diploma course (1968). Traditionally (in Zulu culture), she was expected to remain at home and care for the elders in her new family. Fortunately, she had the support of her husband and he allowed her to continue with her studies and nursing career (Mhlongo 1998:76).

3.4.4.1 *European nurses encounter cultural and social challenges in South Africa*

While African nurses had to overcome challenges of education and cultural tradition, European nurses faced the challenge of a new continent and its very different cultures and physical conditions. The African people's beliefs in magic and traditional medicine required European nurses to communicate the purpose of Western treatment very well – a feat made very difficult due to the language and cultural barriers that existed. They had to care for patients with (to them) unknown diseases such as malaria, cholera, bilharzia and kwashiorkor in a country filled with wild animals, unknown insects, little water and great heat. The English climate is mild in comparison. Pakenham (1992:183) describes Kimberley, where Henrietta Stockdale lived and worked, as a "God-forsaken spot" with a climate that was "... severe, even by South African standards: dust-storms in summer, blowing in from the Kalahari desert to the north-west; icy winds on winter nights that could kill a man caught out in the veld" (Schultheiss 2010:155; Sweet 2004:180).

3.4.4.2 *Black South African nurses: caught between two cultures*

Europeans had the notion that black people were childlike and controllable. This "paternalistic attitude" (Brits 1993:216) was an international stereotype shared by white people in the United States of America (USA), Europe and South Africa. They largely based this view on their observation of black patients' behaviour in the unfamiliar western-styled hospital environment and, due to the social distance that existed

between black and white, their view was seldom challenged. This social distance also created a situation of miscommunication among nurses: white nursing supervisors had little understanding of the cultural barriers and difficult, dual social position their black nurse probationers were facing. As nurses they were held in high regard by their own people. They became the westernised elite, marrying lawyers and ministers of religion; their weddings featured in the columns of the social newspapers of the day. (Institutions such as Lovedale assisted in developing the African elite, who would play a major role in the politics of early twentieth-century South Africa.) Yet, as black women in the broader sense of South African society, they were accorded a low social status on the grounds of their race and gender. This duality in social status led to unrest and strikes from the 1920s onwards, including the strikes at the Lovedale and Sulenkama hospitals in 1949 (Marks 1994:57, 100–101, 105–106; Spies 1993:28; Sweet & Digby 2005:115, 120; The question ... 1907:9).

Florence Nightingale and Henrietta Stockdale unwittingly succeeded in their efforts to attract educated women from the higher classes to the nursing fold, although the “ladies” in question did not comply with the Eurocentric perspective of the time. These African ladies were taught the art of Western style nursing and they were expected to provide health care (and health education) to the largest group of South African people, namely the African people. Black nurses followed the example of the “lady nurses” by adhering to Christian values and using the candle-lit ceremony at special occasions. However, the African society of the early twentieth century mistrusted Western style medicine and strongly believed in the traditional, African health perspective. This placed the black professional nurse squarely between two cultures with opposing health belief systems. The matter was discussed at the Bantu Trained Nurses Association’s (BTNA) 1939 conference: “In many cases our Bantu people still believe strongly in witch-craft and superstitions, therefore making it hard for trained nurses to carry out their duties effectively” (Marks 2004:100–101; Mashaba 1995:31; University of Witwatersrand 1939:5).

The researcher believes that this is a situation which, even today, many black professional nurses face. During a recent class discussion about the differences between African and Western health belief systems, it became evident that African nursing students who train and nurse in Western-styled health institutions at times feel trapped between the scientifically minded Western content taught in lectures and their

African patients' (and their own) health beliefs. They perceive Western health institutions as not caring for a patient holistically and (as an example) are at times reluctant to provide health education regarding the pharmacological action of medication based on scientific, physiological facts. They fear the patients will perceive their explanation as witchcraft. Professor TG Mashaba, the first Head of the Department of Nursing Science at the University of Zululand, recognised this cultural divide and stated that her first reaction to Western society was one of "non acceptance" but thought it was "... up to Blacks [themselves] to investigate [the] means of trying to disengage from the undesirable traditional practices" (Mhlongo 1998:127, 165).

3.4.5 Early efforts to increase the number of black professional nurses

In an effort to increase the number of black nurses in training, Lady Gladstone, wife of the British Governor General, started the King Edward VII Memorial order of Nurses in 1911. Contributions received from black people were used to train African and coloured nurses. (As Afrikaner women had similar problems with the English system of nursing, the order was criticised by the Afrikaner press for not having a similar project to assist Afrikaner women.) Despite efforts to facilitate the entry of black women into nursing and the urgent need for more nurses, progress was slowed down by racialised political and economic issues (Marks 1994:67; Searle 1972:271–275).

In later years, the BTNA designed leaflets which were printed and distributed to inform "Bantu girls" about nursing. Along with the information leaflet, the girls were also provided with a list of hospitals that provided training to black women (University of Witwatersrand 1935:1).

3.4.5.1 *The debate about the category 'lesser-trained nurse'*

A debate regarding the acknowledgement of a category 'lesser-trained black nurse' commenced in 1912. Advocates of the secondary (lower than professional) nurse category stated that, if recognised by the medical councils, the less educated black women, who received hospital certificates, could be given formal recognition of training received and their nursing practice could be regulated. Furthermore, the nursing numbers in the country could be increased and especially the black population would benefit from the availability of nursing care. Those opposing the establishment of a

secondary category of nurses feared that it would keep the black nurses in a “secondary” status instead of giving them an opportunity to become professional registered nurses. The author of an article in *The Christian Express* (The month ... 1914:1), a missionary newspaper printed in Lovedale, stated: “... the ordinary nurse’s examination is open for any Native nurse who possesses sufficient ability and a good enough knowledge of English to go in for it”. Others feared the economic implications of establishing a secondary category of nurse: this new category of nurse would be able to work for a lower salary than the professional nurse, thereby threatening the job position of the latter. The issue was only resolved 40 years later with the introduction of the *Nursing Act* of 1957 and, until after the Second World War, greatly hampered the entry of black women into nursing (Marks 1994:67; Searle 1972:271–275).

3.4.5.2 Working conditions in hospitals

English nurses were in control of nursing in South Africa, setting the standards of nursing and nursing training. Until the 1920s, nursing was considered a disgrace for white Afrikaner women – especially after marriage. Also, the death of large numbers of women and children in the British concentration camps during the second Anglo-Boer War (1899–1902) had a negative influence on Afrikaner-English relationships. Thus, few Afrikaner women entered the profession because they did not want to be dominated by the English nurse supervisors. Of those who did enter the profession, many left when they became married women. The strict discipline and strenuous working conditions also forced many to leave. Nursing training was minimal and nursing students were regarded as cheap labour. Yet, owing to the limited number of jobs available to white women, there were sufficient applicants, but insufficient posts available in the hospitals (Marks 1994:68–72; Potgieter 1992:139; Searle 1972:256).

Like their white counterparts, black women faced similar challenges of harsh working conditions, long hours and poor pay. However, they also had to perform domestic labour tasks in the wards, such as scrubbing floors, which white nurses did not have to do. The problems related to training posts and candidates available were similar to those experienced by white women (Marks 1994:102).

3.4.5.3 *Limited nursing student posts*

When the McCord Hospital opened its training doors in Durban in 1909, there were more nursing candidates than posts available. The hospital management only allowed the number of trainees needed to perform the actual work in the hospital. Therefore the hospital's unwillingness to accommodate student nurses in training greatly hampered the number of student nurses entering the profession. Horwitz (2007:132) states that the Baragwanath Nursing College, which opened its doors in 1948, commenced with approximately 300 nursing student posts. Yet, between 2 000 and 3 000 applications were received. This imbalance between the number of student posts available versus the number of applicants did not improve with time: the new Baragwanath College, which opened its doors in 1982, could accommodate a maximum of 1 500 students per year while 20 000–30 000 applications were received. Given that Baragwanath Hospital developed as the largest nursing training hospital for black women in South Africa, the numbers mentioned above highlight two issues. First, it confirms statements that there were few work opportunities available to black women. Secondly, it links with Mashaba's (Mashaba 1995:13; Sweet & Digby 2005:110) and Searle's (1991:98) statements that few black women had the educational background required to enter into nursing. The issue of education was discussed extensively earlier in this chapter. If this perceived lack of educational suitability was evident as recently as 1982, it is reasonable to deduce that it was also a major problem in preceding decades. Thus large numbers of "unsuitable" black nursing candidates were excluded from the profession during times when those most ill and in need of care belonged to the black population of South Africa (Horwitz 2007:131–132; Marks 1994:6; Mashaba 1995:18).

3.4.6 The second Anglo Boer War: the socio-economic impact on nursing after the war

The British social system brought to South Africa by the missionaries – which was based on Victorian values of class, gender and race – came to fruition after the second Anglo-Boer War (1899–1902). The outcome of this war gave the victors, the British Empire, control over rich deposits of gold and diamond fields, thus ensuring British (male) political and economic supremacy in South Africa. The English colonisers considered themselves superior to the "simple and primitive" white Afrikaners who in

turn viewed themselves as superior to the “childlike” black people of the country. This class system (with its implications of race) led to discussions at the 1906 South African Imperial Union Congress about white female nurses caring for black male patients. The obvious solution would have been to train more black nurses; however, that was viewed as a long-term solution. In the short term, the involvement of white nurses in the care of black patients was limited to supervising the work of Indian, African and Coloured orderlies. Marks (1994:58–59) states that this phobia about white women nursing black men had its origin in the dominant English male society that ruled the country at the time. She found very little evidence that the white nurses themselves had qualms about nursing black male patients. In an article written shortly after the 1906 South African Imperial Union Congress, the author of *The Christian Express* (The question ... 1907:9) stated that European nurses had no objections to nursing black male patients. In fact, he stated that European nurses described their black male patients as being more “amenable, respectful and more grateful than European men”. The issue was fuelled by the economic depression of the 1930s, which led to the rural impoverishment and rapid urbanisation of the Afrikaner and African people. More Afrikaner nurses entered the nursing profession as a means of income, and more African people needed hospitalisation due the illnesses caused by poor sanitation and urban living conditions. These socio-economic changes demanded a change in the nature and status of nursing (Marks 1994:52–60, 62–69; Pakenham 1992:64; Schultheiss 2010:155–156; Spies 1993:5, 121–122).

3.5 NURSES IN SOUTH AFRICA: ISSUES OF POWER AND STATUS

The development of black professional nurses must be viewed against the political and economic issues of the day. Therefore, a very brief overview of the political and economic climate before 1944 is required.

3.5.1 The political and economic climate post-World War I (WW I)

WW I (1914–1919) led to major socio-economic changes in South Africa. Although the country’s economy experienced a boom during the war years, the cost of living was very high and wages simply did not keep abreast. Increasingly, rural black and white people became impoverished, necessitating movement to the cities to find work in the manufacturing sector of the economy – even if the wages for unskilled labour were low.

The living conditions for these newly urbanised blacks were harsh: there was a shortage of housing and poor hygienic conditions prevailed, yet they were required to pay more tax than their rural counterparts. In an effort to increase their meagre income, they illegally brewed beer, ran shebeens and the women became involved in prostitution. These conditions contributed to the high recorded morbidity rate for black and coloured people during the Spanish Influenza epidemic of 1918: an estimated 350 000 non-Europeans died in comparison with 250 000 Europeans. Thus the urgent need for effective health care services became evident. In reaction to the Influenza epidemic, South Africa's first Public Health Act was drafted in 1919. People in the cities had limited access to hospitals and health care facilities, but the availability of health care services in rural areas was almost non-existent. In addition, African people were still using their traditional healers and remedies extensively – and at times ineffectively (Brits 1993:163–164; Gaitskell 1982:3; Grundling 1987a:154; Mashaba 1995:15; Searle 1972:255; South African History Online [S.a.]:a; Spies 1993:121–122).

Despite poor conditions in rural areas, a number of black people chose to remain on white-owned farms. The farms at least provided food and shelter, especially during the Great (economic) Depression of 1929–1933. Another motivator was the political climate in South Africa after WW I. General Jan Smuts, the second prime minister of the Union of South Africa, envisioned a parallel development of black and white people. To this effect, the Native Affairs Act of 1920 and the Natives Urban Areas Act of 1923 were passed with the aim of controlling the movement of black people to the cities and providing them with better housing. However, the Native Urban Areas Act did not have the desired effect of slowing black urbanisation and was therefore amended in 1930 to restrict the movement of black women into the cities. Thus, the movement of black families into the cities was restricted by the fact that the men could not take their wives with them. The Pass Law of 1934 made travelling even more difficult (Beck 2000:113; Brits 1993:156–161). It is the researcher's view that black women's entry into the English-dominated nursing profession was severely limited by the limitations on travel and living in urban areas (where more hospital services and nursing training opportunities would have been available), the lack of educational opportunities, and by the traditional role of black women in society. Searle (1972:270) states that training opportunities available in black hospitals were also reserved for white nursing students.

3.5.2 Women's social role after WW I

WW I (1914–1919) changed the traditional role of women all over the world. In South Africa, black and white women had greater social and economic roles to fulfil during the war years. Women had to work in factories that provided the goods needed by the men fighting the war. Therefore women had to be allowed into traditionally male-only areas of work and became accustomed to this “right to work”. This movement of women into the manufacturing industry was, however, limited to white women. Black women were almost totally excluded for two reasons: a very small number lived in the cities (only 6% in 1921) and it was “prevailing practice” not to employ black women (Grundling 1987a:154). An additional burden was the fact that their men folk were labouring in the mining and manufacturing industries, thereby increasing the women's domestic responsibilities for producing the food and goods needed for home. Those black women who did live in the cities tried to supplement their husbands' income by being laundresses, hawkers and, as mentioned earlier, prostitutes. From a political point of view, black women were also not empowered:

“The ANC [African National Congress] remained a male-dominated organisation, with no political role denned for women. Those few women who actually participated at an organisational level concerned themselves with catering and politics was very much a male domain” (South African History Online [S.a.]:a).

It is against this stark political and socio-economic background that black nurses and their professional development should be viewed (Beck 2000:122; Brits 1993:193–194; Grundling 1987a:153–155; Marks 1994:120).

3.5.3 Nurses seek professional independence

From the discussion thus far it is evident that women of the late nineteenth and early twentieth century had little control over their domestic and professional lives. They lived in a patriarchal society in which education and job opportunities for women were limited. Even those who managed to become professional nurses had little say in the development of nursing as the control rested in the hands of the (all-male) Colonial Medical Council.

3.5.3.1 *The drive to establish a South African nursing association*

Until 1928, no nurse or midwife represented the profession on the Medical Council board. Thus, with the aim of promoting the idea of nursing representation on the Medical Council, Dr John Tremble and Miss JC Child led the drive to launch the South African Trained Nurses' Association (SATNA). The short-term aim was to get nursing representatives on the Medical Council; the long-term objective was the establishment of an independent nursing council. As early as 1905, there was a drive to establish a nursing association with links to the Royal British Nurses' Association. This effort came to nought as it was strongly opposed by Henrietta Stockdale, who envisioned South African nursing as an independent, self-regulating profession. Stockdale died in 1911; four years later, in 1915, SATNA was established; and its first meeting was held in East London. The association admitted only white female registered nurses and midwives as members: no students and no black nurses were admitted (Marks 1994:117; Searle 1972:239–242).

3.5.3.2 *SATNA campaigns for nursing representation on the South African Medical Council (SAMC)*

Campaigning by SATNA led to the formulation of a draft bill in 1923 and ultimately to the Medical, Dental and Pharmacy Act (13 of 1928) which supported the concept of nursing representation on the medical council. In addition, it established registers for midwives and "... nurses, including medical and surgical nurses, fever nurses, sick children's nurses, mental nurses, male nurses and any other description which the council may adopt to denote any particular class of nurses". The Act did not refer to any distinction related to race and stated that "... all persons referred to in section *fourteen* [professional medical practitioners, dentists, chemists, nurses or midwives] shall ... be enrolled upon the register applicable to those persons". Section 29 of the Act rather reflected the patriarchal state of society by stating that a registration certificate would be issued to a nurse or midwife who "... bears a good character and is recommended by one or more medical practitioners under whose supervision such person has worked as a fit and proper person to practise as a registered nurse or registered midwife respectively ..." (Marks 1994:117–119; Searle 1972:245; South Africa 1951:15, 33).

For the first time (after 13 years of campaigning) in their history, South African white nurses had two representatives on the Medical Council, namely Miss BG Alexander and Mrs LL Bennie. The Medical Council retained control over nursing training, examinations and registration. The wording of the legislation confirms the prevailing patriarchal dominance by only referring to “he” when stating the role(s) of the board members. Black nurses were left out in the cold. Although Searle (1972:242) explains the exclusion of non-registered professional nurses, no reason is provided for the exclusion of black professional nurses. One single sentence simply states: “Ledetal was ook tot Blankeverpleegsters beperk” [“Membership was also limited to white nurses”] (Searle 1972:242). In Searle’s analysis of SATNA’s shortcomings, black nurses are not mentioned at all: she only criticises the exclusion of student nurses from the Association and the unwillingness of large numbers of Afrikaans-speaking nurses to participate. She states: “Vroue wat in die land gebore, getoë en opgelei is, kon ‘n selfs groter bydrae tot die ontwikkeling van verpleging in Suid-Afrika gelewer het as vroue wat oorsee gebore en opgelei is ...” (Searle 1972:248). In this Afrikaans quotation she criticises white Afrikaner nurses’ professional indifference by stating that women who were born and bred in South Africa were in a better position to contribute to the growth and development of professional nursing than women who were born and trained overseas (Marks 1994:43, 114–117, 119, 123–126; Searle 1972:238–248; South Africa 1951:9). This statement can certainly be applied to black nurses in South Africa as well: they were born and bred in this country and can therefore also greatly contribute to nursing in South Africa.

3.5.4 SATNA objectives and stance towards black professional nurses

Although SATNA barred black nurses from the organisation, it did recognise the need to train black nurses and therefore, in 1919, urged the Medical Council to establish a “Native Nursing Service” (Marks 1994:90) and in 1928 again stated its support for the establishment of training schools for non-Europeans. The number of nursing schools for black women was limited: during the period 1907–1918 only one nursing school offered training, and by 1924 two such nursing schools existed. (An increase in black nursing schools and nursing-student numbers was only evident during and after World War II.) The debate regarding a lower qualification for less well-trained black nurses also continued with some (including SATNA) opposing and others supporting the idea.

The need for nurses, even if less well-trained, was weighed up against the prevailing issues of ethical control over patient care and political ideology. Searle (1972:274) strongly condemned the fact that black social and health needs were left unattended while politicians debated. Unfortunately, it was only after World War II (WW II) (1939–1945) that the issue of black professional nurse training received serious attention, although the ill-health of the African population and the high infant mortality rate had already become a concern in the late 1920s. The matter of training schools for non-European nurses dragged on until 1932, when the newly formed South African Institute of Race Relations held a conference in Bloemfontein to discuss the issue. Despite the fact that the conference was held to discuss the training of black nurses, not a single black nursing delegate was present. The only influence on discussions was indirect by means of comments and protest by African medical practitioners, the Native Welfare Society and the Transvaal Native Congress. It does not appear as if the opinion of black nurses was asked or considered at all (Marks 1994:90–93, 95–97; Mashaba 1995:24; Searle 1972:271–274, 309).

3.5.4.1 *The 1932 Bloemfontein Congress*

The 1932 Bloemfontein Congress, held under the Chairmanship of Mr Rheinalt-Jones from the South African Institute of Race Relations, consisted of 32 attending members who met for one day on 17 June 1932. Organisations which were represented included branches of the National Council for Child Welfare, National Council for Women; South African Institute of Race Relations; Girls Wayfarers' Association; Union Health Department and municipalities of the larger metropolitan areas. Also present were the hospital boards of Kimberley, Cape Town, Pretoria, and Bloemfontein; as well as representatives of the missionary hospitals in Durban and Aliwal-North. Significantly, two members from the nursing profession were present – Miss BG Alexander and Mrs W.G. Bennie. The conference convened at 9.30 and by 12.45 the issue of training for black nurses had been concluded (University of Witwatersrand 1932b:1–3, 5).

At the 1932 Bloemfontein conference, Miss BG Alexander made the following proposal that was seconded by SATNA vice-president Mrs WG Bennie and adopted as a resolution by the conference (Marks 1994:96–97; Mellish et al 2010:49; Mortimer & McGann 2005:112; University of Witwatersrand 1932b:4):

- Lower-certificate hospital training would be acceptable in the interim. This proposal was accepted in an effort to increase the number of nurses available in the country. Especially the health of people in the so-called reserves was of concern. Dr Hamilton Dyke, Principal Medical Officer of the Bechuanaland Protectorate Government, presented a paper on this matter, pleading for “simplified training for young Native women” (University of Witwatersrand 1932b:3).
- The training qualification however, could not be registered with the Medical Council as the council did not issue certificates based on colour or race.
- This lower-grade training was thus subsidised by the South African Native Trust, the governing body which, under the Native Trust and Land Act of 1936, had the responsibility of managing the African Reserves’ agricultural development.
- Hospital training that did not meet medical council requirements had to be standardised.
- All training hospitals which had the facilities to train black nurses for the full Medical Council Certificate were urged to start training “... without delay” (University of Witwatersrand 1932b:4).
- The nursing profession admission requirements were raised.

3.5.4.2 Nursing entry requirements raised

Searle (1972:309) states that SATNA set the goal of establishing university graduate courses in South Africa. The researcher believes that the raising of entry requirements was proposed with this goal in mind, although the issue of establishing nursing as a profession possibly also contributed to the decision. Statistics for the year July 1930–June 1931 indicate that black nursing candidates entered the field with Standard VII (67%) and Standard VIII (33%) as their highest school qualification (Mashaba 1995:21; Searle 1972:298). No black student had a qualification higher than Standard VIII (Grade 10). The 1932 conference stated that the minimum educational requirement for admission to the medical and surgical nursing course was Standard VII (Grade 9), with the additional requirement that the applicant should be at least 18 years old. Black nursing candidates were also encouraged to do teacher training or a course in domestic work (a so-called industrial course) first in order to better prepare themselves for the educational demands of nursing (University of Witwatersrand 1932b:5). The

statistics did not improve over time: the July 1940–June 1941 statistics indicate that only 4% of black nursing students had a Standard X (Grade 12) and 12% had a Standard IX (Grade 11) qualification. Although raising the entry level demanded academically strong nursing candidates and, by extension, growth in the science of nursing, it also kept a large number of less educated black women out of the profession. Buthelezi (2004:3) refers to this raising of qualifications as “gate keeping activities” by Afrikaner nurses. However, it must be remembered that the leading roles in the development of nursing before 1944 were not filled by Afrikaner women, but by European (British) women. The role of Afrikaner women only became evident after 1944 and will be discussed in chapter 4 of this dissertation.

3.5.4.3 SATNA changes its position regarding a lower qualification for less well-trained black nurses

When South Africa’s first public health legislation was framed after WW II, SATNA supported the concept of a lower qualification for less well-trained black nurses – on the understanding that these nurses would only take care of black patients. This position was in stark contrast to SATNA’s pre-WW II (before 1939) view when they strongly opposed a lower qualification for nurses. During the 1932 Bloemfontein Conference, there were two issues to consider regarding the concept of a less well-trained nurse: there was an urgent need, especially in the ‘Reserves’, for any form of trained nurses. Yet, professional nursing was in its infancy and therefore needed protection. A resolution was made by the conference to create a subcommittee whose task it would be to “draw up a scheme for training non-European nurses, male and female, on a lower-grade curriculum and examination than those of the South African Medical Council ...” (University of Witwatersrand 1932b:4). These less well-trained persons would not be referred to as nurses, but as “health workers” and the Royal Sanitary Institute (not the Medical Council) would be asked to act as registering and examination body. Also, these less well-trained health workers would only be allowed to work in specific areas. Miss BG Alexander and Mrs WG Bennie were chosen to serve on the subcommittee convened by Dr HA Moffat. They were the only women on this subcommittee (Marks 1994:90–93; University of Witwatersrand 1932b:4).

SATNA’s position regarding the lower qualification was confirmed by a letter found in the archives: Dr Moffat had written the letter on 26 July 1932, shortly after the

Bloemfontein conference and the establishment of the subcommittee. It is not clear who the recipient of the letter was, but it bears the heading “Proposed Special Nursing Training for Native Areas” and the salutation “Dear Sir”. From the content and tone of the letter the researcher deduces that the letter was written to a member of the Bloemfontein congress, possibly the ‘chairman’. The first three paragraphs of the letter summarise the decisions made at the Bloemfontein Congress. The fourth and fifth paragraphs state the view of the two SATNA representatives (University of Witwatersrand 1932a):

“The Trained Nurses’ Association is properly anxious that the institution of any such lower grade of nurse should not in any way lead to the lowering of the standard of education, preliminary or professional, or of the status of the Trained Nurse or Midwife under the Union Medical Council, and the Representatives of the Association at the Conference were most desirous (sic) that the proposed lower grade training should not be associated with the Medical Council, but should be managed ... by some other body, so that no confusion with the Union Council’s Certificates would be likely. They were also anxious that the term ‘Nurse’ should not be applied to the holders of the lower grade certificate.

Provided that it can be assured on these points, the Trained Nurses’ Association is ready to co-operate in trying to institute a grade of ‘Health Worker’ on the lines of the training indicated above.”

The researcher deduces that the post-WW II change in SATNA policy was in line with the proposed parallel development for black and white people initiated by South African politicians after WW I and discussed in sub-section 3.5.1 of this chapter. After WW II, the rise of the National Party (NP) escalated this path of parallel development. The letter also confirmed previous statements that women in the early twentieth century did not have a strong socio-political voice. South African society was strongly patriarchal in its social, political and economic expression as was evident from the fact that Dr Moffat, not the women themselves, presented SATNA’s case in writing.

3.5.4.4 *Black professional nurses' reaction to SATNA*

Considering the time line, black nurses organised themselves shortly after the 1932 Bloemfontein conference. In reaction to their exclusion from SATNA (and the conference), black nurses formed the BTNA in 1932, an association which was recognised by the International Council of Nurses (ICN). In this they were assisted by Ruth Cowles, an American Board missionary. By 1937, the Association had 40 members and two branches: one in Johannesburg and a second in Durban. They also established their own journal with the title "Bantu Nursing Journal". The Association set themselves several objectives, such as improving professional and educational development and improving the standard of nursing training for black women. A handwritten letter by Gloria Mamabolo explains the first meeting of the Association on 5 November 1932 and confirms the aims of the association. The letter also states that the Association had 30 members: 12 were full members and the rest had indicated their intention to apply for membership. Meetings were planned for every second Sunday of the month (Gaitskell 1982:13; Marks 1994:100; Mashaba 1995:30; Oberlin College Archives [S.a.]; Searle 1972:247, 275; University of Witwatersrand [S.a.]; University of Witwatersrand 1937:1).

The minutes of the second annual meeting held in Doornfontein on 9 December 1934 confirm that the BTNA by that time had 24 full members. The decorations for the meeting reflected the Association's chosen colours of blue and silver. The BTNA had also designed an own badge with the inscription "Loyalty". The President of the BTNA was Caroline Zondi. Also present at the meeting were Mrs and Miss Bridgman, Miss Cowles, Dr Chapman, Dr AB Xuma and Mr JD Rheinalt-Jones. Members of SATNA were also present, namely Mrs E Winter and the organising secretary of SATNA, Mrs HC Horwood. The minutes of the meeting further state that Miss Cowles had represented BTNA at the June 1934 Conference of the Central Governing Board of the South African Trained Nurses Association: "Resolutions sent to that Conference had been most sympathetically received and supported". This document confirms that there was contact between SATNA and BTNA, albeit in a non-representative form for black nurses as their cause had to be represented by Miss Cowles (University of Witwatersrand 1934:1–2).

The BTNA held two conferences: the first on 29 March–1 April 1937 and the second on 10–12 April 1939. The archives which the researcher visited only had the agenda for the first conference but neither the minutes of the meeting nor a report on it. However, the archives did have the minutes of the second conference held at the McCord Zulu Hospital in Durban in 1939. Several issues, including the salaries of black nurses, a Nurses' Sick Fund and the nursing of "Bantu patients" by "Bantu nurses", were discussed. The conference also decided to give the task of maintaining a register for Bantu Nurses to Mrs Rheinalt-Jones of the Institute of Race Relations. The lady-like nature of these black nursing pioneers is evident from the minutes of the meeting and confirms the discussion in sub-section 3.4.4.2 of this chapter: there were musical solos, tea, gifts to the speakers and "... a lovely bouquet of red roses ..." to Miss Ruth Cowles (University of Witwatersrand 1939:1–3).

The BTNA was disbanded in 1944, when the first Nursing Act made membership of the South African Nursing Association (SANA) compulsory, thereby taking control of all members belonging to the nursing profession (Searle 1972:275).

3.6 WORKING CONDITIONS, TRAINING AND WORKING OPPORTUNITIES: 1908–1944

Black women who were able to enter the world of professional nursing faced the challenges of strenuous working conditions, limited training opportunities, and even limited job opportunities after qualifying.

3.6.1 Limited nursing training opportunities for black women

Two main hospitals were involved in the training of black professional nurses, namely Victoria Hospital in the Eastern Cape and the American Zulu Mission Hospital (later the McCord Hospital) in Natal. The Victoria Hospital, being part of the Lovedale Mission, opened its doors in 1903 and produced the first black professional nurse, namely Cecilia Makiwane. The American Zulu Mission Hospital commenced training in 1910. The training of black nurses in the Transvaal was delayed until 1939 and in the Orange Free State it was only commenced in the 1950s. Smaller mission hospitals were encouraged to train black nurses in order to provide nursing staff to hospitals in remote areas of the country. The training of black professional nurses was also viewed as an

opportunity to educate African people. Unfortunately, the plan had its problems: it was a challenge to find suitable candidates, as they were expected to write the nursing examinations in English or Afrikaans – a feat few black people could manage in the early twentieth century due to the lack of educational opportunities. Training opportunities for black nurses were also limited because European nurses required the learning opportunities provided by black *and* white patients in order to qualify. Moreover, once trained, the nursing staff left the small mission hospitals and moved to larger hospitals which could provide them with a greater variety of patients – and thus experience (Marks 1994:83–89; Mashaba 1995:4, 11; Mortimer & McGann 2005:110; The employment ... 1911:2; The question ... 1907:9).

Shortly after opening its doors in 1909, the McCord Zulu Hospital in Durban commenced with a three-year hospital certificate course in nursing – the first intake being in 1910. Candidates were required to have a Standard V (Grade 7) certificate. The hospital gradually increased its training standards so that they were able to gain recognition from the Natal Medical Council as a training school and thus they were allowed to offer the full professional nursing course by 1924. In order to be admitted to the nursing school, black women were expected to have a Standard IX (Grade 11) school qualification. Owing to this high educational standard, they had few academic failures with their students and their professional care greatly contributed to changing the African population's opinion of western hospitals (Holst 2011; Mashaba 1995:17-21).

3.6.1.1 *Limited training opportunities place a burden on qualified black nurses*

It is this researcher's conclusion that, in the light of the general standard of education at the time, the small number of nurses thus produced was insufficient. For example, by 1924 there were only 753 black children in high school, the black population had urgent health needs (in the years 1929–1930 Johannesburg had an infant mortality rate of 705 per 1 000 births and Pretoria 388 per 1 000 births), and there were very few training institutions for black nurses. There were 23 black student nurses in 1936, 40 in 1940, and 51 in 1941. Educational facilities for black students were gradually improving, thus providing the nursing schools with academically better equipped candidates. But at the same time, African people were burdened with ill health and had become less resistant to Western style medical care, and thus the patient numbers increased. Nursing

numbers could not keep up with the demand. To illustrate the point: in 1921, nurse Dora Jacobs, a 'product' of Victoria Hospital's four-year course, was in charge of the New Brighton Hospital in Port Elizabeth. She was one of two trained black nurses working there. A doctor visited the hospital three times per week. New Brighton Hospital served a community of approximately 7–8 000 people. Another example is that of the two black nurses in Alexandra Township, who made over 3 000 house calls to patients in the year 1930. It is an overwhelming nurse: potential patient ratio (A Native nurse ... 1921:190; Brits 1993:216; Gaitskell 1982:14; Lovedale news 1919:159; Marks 1994:93; Mashaba 1995:19, 33–34).

Mashaba (1995:9) states that nursing training under the Colonial Medical Council had no racial exclusion policy. This is also confirmed by discussions earlier in this chapter. The Cape Colony Medical Council believed that the training of black nurses should be exactly the same as that of white nurses. This was an admirable standpoint, but it also meant that few black women were trained in the first half of the twentieth century, mainly due to the lack of educational opportunities and the limitations placed on them by cultural belief systems. Their entry into the profession was also hampered by political debate. On the one hand, there were questions regarding the suitability of black women for nursing, but on the other hand some white people, especially men, objected to the presence of white, English nurses in black nursing units. Although the superintendent of the King Williams Town Hospital, Dr Fitzgerald, started training black women to nurse the hospital's black patients in the 1860s (consider the fact that trained white nurses only arrived in South Africa in the late nineteenth century), it was not general practice as the debate continued from 1850 until 1912. While this debate continued, no specific plans were made to develop the work of black nurses into a profession. Rather, their training was driven by the social needs of the black population as well as the political debate regarding white nurses taking care of black patients (Marks 1994:52–56; Mashaba 1985:650; Mashaba 1995:3; Mortimer & McGann 2005:110; Searle 1991:97).

In 1906, the South African Imperial Union Congress resolved to increase the training of black nurses, yet little was done due to white opposition and the lack of educational opportunities. It was too costly to build segregated hospitals and there were simply not enough black nurses to staff these hospitals. Politically, European men also manipulated public white opinion with their reference to the "black peril". The perception

was that black men were dangerous and that no white woman was safe from them. This scare contributed to the “white women in black nursing units” debate coming to a head in 1912.

Prior to 1912, white women were only expected to supervise the work of Coloured, Indian and African nurse orderlies. Then a clause was added to the Hospital and Charitable Institutions’ Ordinance no. 5 of 1912 which defined nursing as the “management of servants” (Marks 1994:53) and not the hands-on care of patients.

This definition was in line with the role that white women played in European society, and it immediately relegated the other racial groups to the class of “servants”. Ironically, nurses themselves rejected the idea that they could not nurse black men. However, Marks (1994:56) speculates about white nurses’ apparent willingness to nurse black patients: was it due to ethical considerations or a political move to prevent the employment of black persons? As regards the frightful stories about black men abusing white women, the opposite was true. In 1903, Dr MacVicar felt obliged to close down the white ward of the Victoria Hospital due to the male patients’ disrespectful behaviour towards black professional nurses (Marks 1994:52-6, 83–85; Mashaba 1995:13; The question ... 1907:9).

Training statistics (61 hospitals participated in the survey) for black nurses were presented at the 1932 Bloemfontein conference (University of Witwatersrand 1932b:4):

- There were 57 black nurses in training for the General Nursing Certificate of the Medical Council.
- Twenty-five black nurses were training for the Midwifery Nursing Certificate of the Medical Council.
- Approximately 125 nurses were training for the hospital certificate only.
- Three hospitals provided full training to black nurses.
- Three hospitals provided midwifery training to black nurses.
- The length of training for the Medical Council Certificate was 3–5 years.
- The length of training for the hospital certificate was 1–2 years.

The dire need for training facilities was evident and confirms Dr Hamilton Dyke's urgent plea for nurses at the 1932 Bloemfontein conference.

3.6.2 Barriers to black nurses completing their training

The influence of British nurses became evident in the training system that developed in South Africa. After the second Anglo-Boer War (1899–1902), trained British nurses accepted posts in South African hospitals. Owing to their prestige of having been trained “overseas” they were placed in positions of power. However, most of these nurses had received their training in the Poor Law Infirmarys of Britain, which was the system of workhouse hospitals. Therefore they themselves had been trained in what became known as the apprentice system of training: they were taught in practice, but received very little theoretical knowledge (formal education). The implication for South African nurses was that those in power did not have the training skills needed to educate and train aspiring young professional nurses. Moreover, the demand for nurses was limited to hospital needs: the health needs of the community were not considered by politicians, doctors or even the nurses themselves. Therefore the number of nurses trained and the type of training they received were guided by the labour needs of the hospitals. Nurses were considered, firstly, as a work force; secondly, as students. They worked long hours, signed a strict working contract and attended classes in their off-duty time (if presented at all). This limited the number of nurses trained significantly. The strenuous training conditions also led to examination failures and a high drop-out rate among student nurses. A 1942 SATNA survey indicated that 37% of black student nurses were lost in this manner compared to a 53% loss in Class I nursing schools and 50,5% in Class II nursing schools. (Class I schools had a 3½ year nursing course, while Class II schools had a 4½ year nursing course). Although the provincial medical councils did prescribe curricula from 1910, and objections against the apprentice system were raised by Dr John Tremble in November 1914, the apprentice system remained in use until the establishment of the SANC in 1944 (Mashaba 1995:31–32; Mellish et al 2010:49; Potgieter 1992:140–141; Searle 1972:287–289).

3.6.2.1 Early efforts to train and employ more black nurses

By the 1920s, the debate regarding the training of black nurses had begun afresh. This was caused by the shortage of white nurses in the country and the failing health of the African population (as illustrated by the extremely high infant mortality rate: in the years 1929–1930, Johannesburg had an infant mortality rate of 705 per 1 000 births and Pretoria had an infant mortality rate of 388 per 1 000 births). Therefore, more African women were being trained to be employed as nurses, and several commissions, such as the De Vos Committee (1925), the Loram Commission (1928), the Native Economic Commission (1932) and the Inter-Departmental Committee on Native Medical Education (1933) recommended that an increased number of black nurses must be trained. This need for more black professional nurses meant that their training had to be reassessed. In 1925, the Minister of Health recommended that the standard of training for black nurses should be the same as that of white nurses. Yet the training standards for black nurses remained a contentious issue and severely limited their job opportunities. Black nurses worked mainly in mission hospitals, mine hospitals, municipal clinics, schools and child welfare services. Municipalities were not inclined to employ hospital certificate nurses as these nurses did not have the training that would lead to state registration (Gaitskell 1982:3; Marks 1994:89, 93–94; Mashaba 1995:15, 20; Mortimer & McGann 2005:111–112).

The 1932 Bloemfontein conference was presented with the following statistics regarding the employment of black nurses (University of Witwatersrand 1932b:6):

- They can only be employed in government or missionary hospitals. The poor economic conditions in the so-called 'Reserves' made independent practice impossible.
- Out of a total of 251 municipalities invited to participate in a survey, only 183 responded.
- Of the 183 respondents, only 22 municipalities employed black nurses.

In total, 34 black nurses were employed in the 22 municipalities. Of these, eleven (11) were fully qualified general nurses while seven (7) were midwives. Two nurses had hospital certificates. The number of nurses "... giving full satisfaction" were 34 (University of Witwatersrand 1932b:6). Based on this feedback, the 1932 Bloemfontein

conference identified additional employment opportunities for black nurses by proposing that fully qualified nurses work in townships to perform general nursing, midwifery and child welfare duties. It was also suggested that “fully trained Non-European nurses [work as] ... Staff Nurses” in missionary hospitals. At the time of the conference, there were only 12 black staff nurses working on “Non-European” hospital wards (University of Witwatersrand 1932b:7).

The limited job opportunities for trained black nurses were due to the attitude of those in power and the black nurses’ lack of state registration. In an article published in *The Christian Express* in January 1911, it was stated that hospital-trained black nurses had difficulty in finding work in the Transkei and the Eastern Cape. Moreover, the article claimed that large industries were not interested in employing black nurses and lamented the fact that there was no South African system similar to that of the British district nurses. Although the author of the article criticised those who suggested that black nurses had to become nurse maids to European children, the patriarchal attitude of the time was evident in the author’s response: “It should be understood that district nurses must take their direction from medical men. They are trained to carry out treatments, not examine patients or prescribe.” The article also confirmed that black nurses came from the elite class: the author referred to “... their parents, most of whom are Native ministers ...” (The employment ... 1911:3).

3.7 BLACK NURSING PIONEERS: 1908–1944

In this chapter, the social, political, cultural, economic and educational barriers that hampered the entry of black women into the nursing profession were discussed. However, the researcher must always consider the human element of historical research. After all: history is about people, their lived experiences and how their reactions to life events shaped the society we live in today.

Although a detailed discussion regarding each black nursing pioneer is not the objective of this study, the researcher deems it appropriate to identify the black women who overcame the socio-political, economic, cultural and educational barriers of the era 1908–1944 in order to be registered as a nurse. It will be the task of future nurse historians to study these nursing pioneers in greater detail.

3.7.1 Lovedale Nursing School produces the first black registered nurse

The first two black women to train at Lovedale nursing school were Cecelia Makiwane and Mina Colani. Only Cecelia Makiwane completed the three-year course and registered on 7 January 1908 (Mashaba 1995:12; Searle 1972:271; South African History Online [S.a.]:b).

3.7.2 The first black nurses qualify at McCord Nursing Home

The first black women to obtain a hospital certificate after three years of training at the McCord Nursing Home in Durban are listed by Mashaba (1995:17) as follows:

- Elizabeth Njapa: she became nursing superintendent of a small hospital in Zululand.
- Julia Mawaza.
- Nomhlatuzi Bhengu.
- Edna Mzoneli, who tragically died after tirelessly nursing the 1918 Influenza victims. She was pregnant and died of influenza two days after the birth of her first child (Mashaba 1995:18).

The entry requirement for these four ladies was Standard V (Grade 7); which in part explains why they received hospital certificates. On the official McCord Hospital website, Holst (2011) states that these four nurses were awarded a hospital certificate because the Natal Medical Council only recognised the nursing school in 1924. Therefore, they could not achieve registered nurse status. Cecelia Makiwane had a Standard VI (Grade 8) plus the T3 educational certificate, and therefore had the educational background to obtain state registration as a professional nurse (Mashaba 1995:17).

3.7.3 Black nursing pioneers recognised by the SANA

Training in Pretoria and the Free State commenced at a much later date. In 1986 and 1989, the SANA published two volumes containing biographical information about those nurses who were awarded Honorary Life Membership of the SANA. The volumes contain short biographies of black and white nurse leaders such as:

- Mavis Victoria Makhetha, who was one of the first black staff nurses to be promoted to sister in 1945.
- Mamoloko Matebese who started a premature unit at Baragwanath Hospital in 1951.
- Jane McLarty, Matron-in-Chief of Baragwanath Hospital and internationally recognised for her expertise in training African nurses.
- Caroline Skele who was the first black matron at Voortrekker Hospital, Kroonstad.
- Ethel Ursula Binda.
- Charlotte Searle.
- Dorothy Sehurutshi.

Although it must be borne in mind that the mentioned nurses were all recognised due to their association with SANA (nurses not active in SANA were not recognised), studying the biographies of the five black nurses mentioned above led the researcher to identify certain similarities that confirm the content of this chapter. The ladies are included here because they commenced their nursing training between 1933 and 1945. Although they completed their basic nursing training at different hospitals, four of them completed their midwifery training at the Bridgman Memorial Hospital, because it was the only hospital in the Transvaal (Gauteng) which provided midwifery training to African women (Gaitskell 1982:18; SANA 1986:73–74, 99, 101, 155; SANA 1989:9, 145).

Four of them came from a privileged (for the time) social background: their parents included teachers, an Anglican Church minister and a sub-deacon. Mrs Binda's mother, Dorothy Langa, was the first black woman to become a high school principal (SANA 1986:73, 99, 155; SANA 1989:7, 145).

There are also similarities with regard to their educational background and nursing careers. Two of the ladies, Mamoloko Matebese and Dorothy Sehurutshi were Wayfarers. The Girl Wayfarers' Association was a youth organisation which was established in 1925 for African girls and it had a representative at the 1932 Bloemfontein Congress about nursing training for black women. The movement

managed to make nursing popular as a career for African girls. Although teaching remained the first career choice, 40% of 1935 African Standard VI (Grade 8) girls in the Transvaal (Gauteng) wanted to become nurses. Mamoloko Matebese and Dorothy Sehurutshi commenced their nursing training at Lovedale in 1933 and 1941 as a mine nurse and staff nurse respectively. All five nurses had nursing careers of distinction and became leaders in their communities. Four of the ladies made extensive contributions to district and school nursing before ending their careers as matrons (nurse managers) in their respective hospitals (Gaitskell 1982:16; SANA 1986:99; SANA 1989:145; University of Witwatersrand 1932b:1–2).

3.8 IN SUMMARY: THE HISTORICAL ERA 1908–1944

The time period discussed in this chapter is wedged between eras of major political and economic upheaval, not only in South Africa, but also in the rest of the world. In 1908, South Africa was still recovering from the devastation caused by the second Anglo-Boer War (1899–1902). Two years later (1910), the South African Union was formed, mainly to provide Britain with a strong military and political basis in Africa as WW I (1914–1919) loomed on the horizon. Twenty years after WW I, the outbreak of WW II (1939–1945) caused all considerations of educational and economic development in South Africa to be put on hold. The two world wars led to the traditional female role being challenged and women becoming accustomed to the right to be economically active. Unfortunately, this right mostly extended to white women, leaving black South African women out in the cold. The economic hardships this caused were exacerbated by the Great (economic) Depression of the 1930s and the South African Union's political ideology. In this dire economic situation, black people migrated to urban areas in increasing numbers to find work in mining and industry. The Union government's efforts to curb urbanisation and improve housing were ineffective and contributed to the poor health of the African population. Yet, despite the dire needs of the largest population group, nurse training was conducted haphazardly and ineffectively. The need for teachers was considered of greater importance.

Despite these hardships, the period 1908–1944 created the developmental foundations on which modern, black professional nursing rests. There was no specific plan that directed the development of black professional nurses – rather their training was driven

by the health needs of the African population and hampered by traditional practices, as well as by the educational, socio-political and economic issues of the time.

In the first part of the twentieth century, few black women received formal, Western styled education. Education opportunities were rare, mostly provided by English missionaries and preferably given to boys. The few girls who did attend formal schools, mostly left before completing their secondary education because they were expected to contribute to maintaining the household. Due to the relatively high education level required by the British professional nurses this educational barrier greatly diminished the potential pool of suitable black girls who could enter nursing.

Even if there had been educated African ladies, culturally they were expected to be the providers of food and health care at home, while the white, nursing sisters expected their nursing students to be free of domestic responsibility and unmarried, like themselves. Certainly this created a barrier to black women entering the nursing profession.

Perceptions of race not only hampered the entry of black women into nursing, but also restricted their professional development. They were excluded from the early (female) drive towards professional independence from the (male) medical councils and thus forced to create their own professional structures. Discussions regarding their professional position and future were conducted without considering them – or allowing them a voice.

Overcoming the educational, social, cultural, political and economic barriers of the time was certainly no easy task. Yet, the remarkable pioneers of black nursing did manage to create the professional foundations supporting the current generation of nurses.

3.9 CONCLUSION

The socio-political, economic, cultural and educational barriers to the entry of black women into professional, Western-style nursing during the period 1908–1944 has been identified and discussed. Included in the chapter is a brief tribute to these remarkable women.

In the following chapter, the researcher will discuss the factors which influenced the development of black women as professional nurses, commencing at the time that the SANC and the SANA were formed on 20 June 1944.

CHAPTER 4

SOUTH AFRICAN NURSING 1945–1970s: STATUTORY INDEPENDENCE AND APARTHEID

Professor Grace Mashaba: *“The only career avenues open to Black girls in the 1950s were teaching and nursing. I cannot say I loved nursing, but I had no other alternative”*
(Mhlongo 1998:74).

“Geen enkele faktor het meer bygedra tot die snelle ontwikkeling van die Nieblankeverpleegdienste as die beleid van afsonderlike ontwikkeling nie”. [No single factor contributed more to the rapid expansion of the non-European nursing services than the policy of separate development.]
(Searle 1972:278).

4.1 INTRODUCTION

Chapter 4 of this dissertation describes the socio-political, economic, cultural and educational factors which influenced the entry of black persons into professional, Western-styled nursing during the 1940s, 1950s and 1970s.

At the outbreak of WW II in 1939, South Africa had approximately 200 black persons registered as nurses with the SAMC. By 1959, there were 4 633 registered black persons on the register of the SANC and this number increased even more: by 1977 there were 18 362. Over a period of 37 years, black nurses became established as one of the largest professional groups. The question is *how* and *why*? (Samson 1978:48, 51; Searle 1972:280).

In this chapter, the development of black professional nurses in the *a priori* period 1945–1970s is discussed. The researcher identified the social, economic, political and educational factors which influenced the development of black professional nurses from the time that Nursing Act (45 of 1944) – which led to the establishment of the SANC and the SANA – was gazetted on 20 June 1944 up to the 1970s. During this period of history, the rise of nursing as a self regulated profession, which occurred simultaneously with the WW II and the rise of apartheid in South African politics, is discussed (Beck 2000:125–126; Searle 1972:232; South Africa 1944).

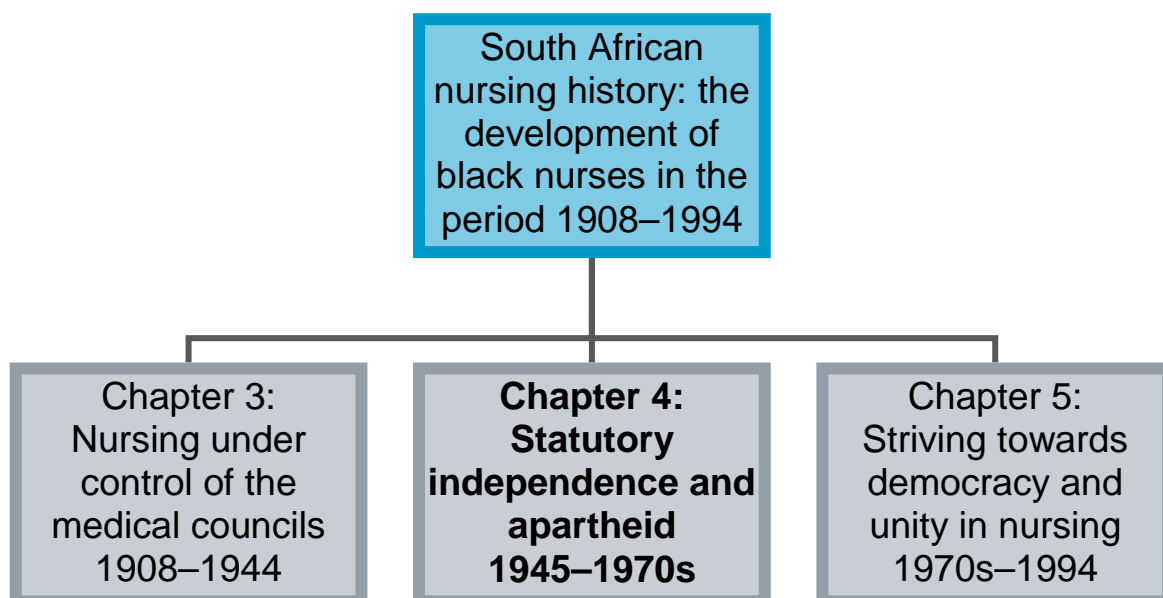


Figure 4.1 Schematic representation of the *a priori* periods discussed in this dissertation
(The period discussed in this chapter is represented in bold.)

4.2 HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER

In an effort to identify the economic, socio-political and cultural factors which influenced the development of black South African nurses, the researcher used literature sources that provided the most valuable and context-specific information. These include history books on general South African history, books on the history of nursing in particular, South African Acts, minutes of meetings, as well as original reports found in the archives. Wherever possible, primary sources were accessed to confirm or refute the description of events provided by the secondary sources. This contributed to the trustworthiness of the chapter (Nieuwenhuis 2010:74).

In this chapter, quotations from primary sources and nursing Acts are occasionally used to confirm statements or views expressed in the secondary sources. At times, this posed an ethical problem as some primary sources used words to refer to African people which are currently considered derogatory. Thus in the *a priori* period 1945 to the 1970s, newspapers, legislation and the minutes of meetings often refer to “Native” or “Bantu” nurses. Mashaba (1995:50, 62) states that the word “Native” was replaced by the word “Bantu” in the Nursing Act (69 of 1957) as amended. It was only in 1978 that legislation removed the word “Bantu” from official terminology. For the sake of clarity and accuracy in quoting, the researcher retained the word “Native” or “Bantu”

where it was used in a primary source, legislation or in a quotation. In all other explanations and discussions, the researcher continued to use the descriptive words “African” or “black”.

A few of the secondary sources used in this chapter – for example, the 1978 training report issued by the SANA – were issued in the Afrikaans language. Other SANA documents were available in English. To distinguish between the documents, those written in English and published by the South African Nursing Association are referenced by using the abbreviation SANA. The Afrikaans equivalent, Suid Afrikaanse Verpleegstersvereniging (SAVV), is used when referencing data from secondary sources written in Afrikaans. Figure 4.2 provides a brief outlay of the topics discussed in this chapter.

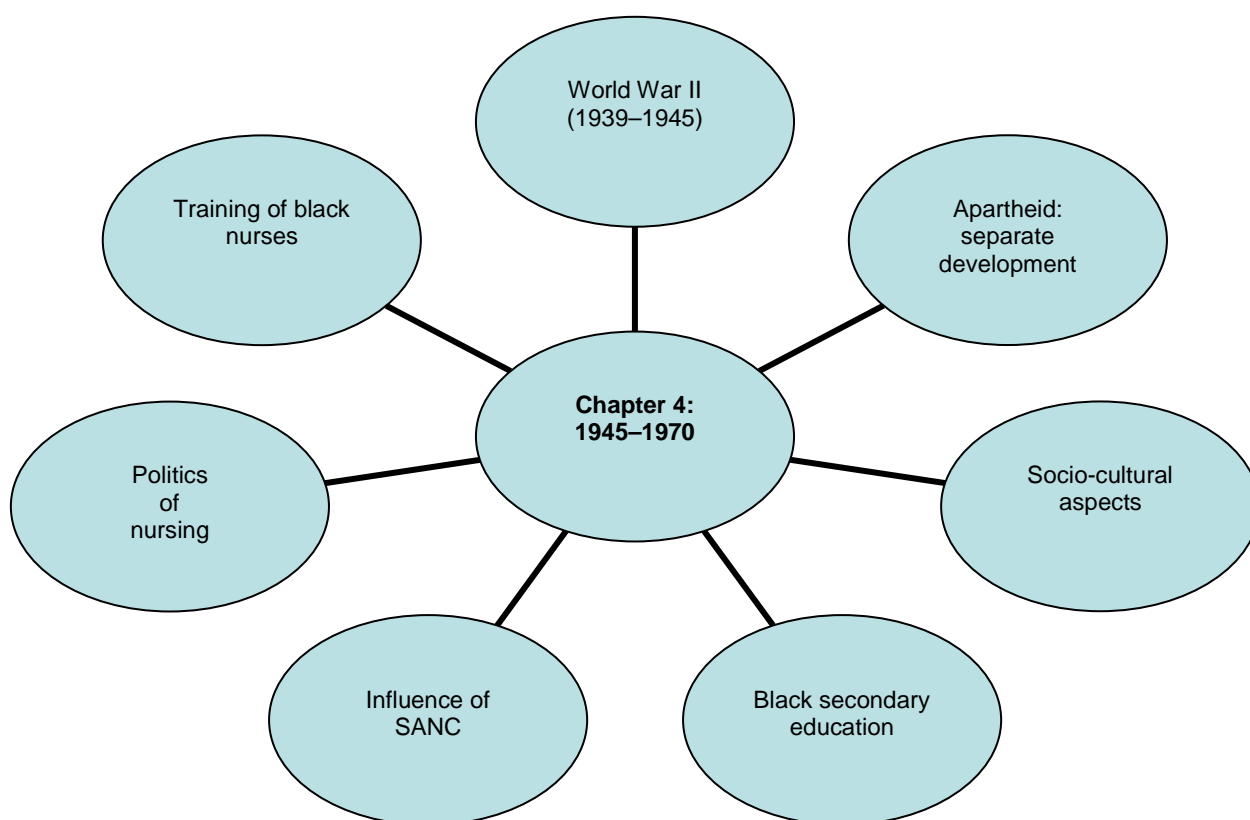


Figure 4.2 Schematic representation of the topics discussed in the *a priori* period 1945–1970s

4.3 THE INFLUENCE OF WW II ON THE DEVELOPMENT OF BLACK PROFESSIONAL NURSING IN SOUTH AFRICA

The socio-economic conditions in which a community finds itself influence the task of the nurses who serve the members of the community because they determine the type of illnesses the nurses are challenged to prevent and heal. The conditions also determine the number of nurses needed in a particular community. Yet, an even stronger influence than social issues and economics exists: politics.

4.3.1 South African politics before and during WW II

Prior to Afrikaners becoming a political force, South Africa was ruled by British politicians, who introduced an ideology of segregation and referred to “the native question” when discussing the black people living in South Africa. Grundlingh (1993:297) refers to this policy of segregation as one of “benevolent paternalism” (Mortimer & McGann 2005:121).

The South African Union Party was in power from 1934 to 1948; thus before and during WW II (1939–1945). Leadership was first given to JBM Hertzog and then, during the war years to General JC Smuts. An important issue during the 1938 general elections was the issue of the supposed “black peril”. Therefore Afrikaner politics built on the train of thought commenced by English politicians (Grundlingh 1993:276–278).

JBM Hertzog, who was the leader of the Union Party from 1934 to 1939, focused on three major political issues, which were greatly influenced by the poor relationship between the English and Afrikaner people. It must be remembered that English-speaking persons viewed Afrikaners and African people as inferior (note discussion in chapter 3, sub-section 3.4.6). Hertzog focused on the need to establish equality between all white people, the need to put South Africa’s interests before those of Britain, and the issue of racial segregation. In a similar vein, Smuts (leader of the Union Party 1939–1948) supported the idea of “greater unity” among white people but did not wish Afrikaners to become a culturally distinct group. Smuts also planned to provide South Africa with a modern economy (Grundlingh 1993:276–277).

4.3.2 Socio-economic conditions during WW II

Because of WW II, inflation rose steeply from 1939 to 1944. South Africans had to adjust their lives on all levels because the war effort was given first priority: staple food was 91% more expensive, petrol was rationed, and the building of private homes was discouraged. Even ladies' fashion had to adjust and therefore dresses short in length; without frills, pleats or extra buttons became popular (Grundlingh 1993:292–293, 304).

Added to the economic woes of the war effort, agricultural conditions in the northern Transvaal (current day Gauteng, Mpumalanga and Limpopo) were poor. Farmers experienced a severe drought which lasted from 1941 to 1943, and therefore the mealie [maize] harvest was poor. This led to farmers dismissing black farm workers, who found themselves unemployed during a difficult economic period. To survive and support their families, black men joined the WW II army in non-combatant roles (e.g. cooks) or moved to the cities to find work. Unfortunately, conditions in the cities were not ideal: food was expensive, accommodation was inadequate, and those who found work received a meagre wage (Adhikari 2006:32; Grundlingh 1993:290–291).

The South African economy strengthened during the war years, with the industrial output doubling and the industrial work force increasing by 50%. Most white men were away fighting the war and therefore the industries obtained their work force from white women and black families moving in from the rural areas. The influx of black people from the rural areas to the cities provided a work force to industries at a time it was needed the most. In 1934 there were 85 000 black persons working in industry; by 1946 there were 250 000 (Grundlingh 1993:294–295).

Yet, this rapid urbanisation, combined with the limits put on building houses, led to the development of slum areas and the illegal occupation of land by 1944. Within four years, approximately 100 000 people lived in slum areas in and around Johannesburg. In 1937, there were 1,1 million (18%) black people living in cities. By 1950, approximately 2,5 million (30%) black people were living in cities. This influx of people occurred despite 1937 legislation (Natuurlike-wysigingswet) to prevent it (Adhikari 2006:30–31, 34; Grundlingh 1993:294–295).

WW II and rapid urbanisation had a great influence on the social customs of black and white people. Although the traditional role of women remained intact, more work opportunities were made available to them during the war years, because the men were away fighting as soldiers. White women could also participate in the war effort by joining the South African Women Auxiliary Services or going to North Africa and Europe to serve as military nurses. This had a profound effect on women and their entry into nursing after the War. Jobs and professions other than nursing were now available to women. Therefore the strict discipline, long working hours and low salary of nurses were no longer the first choice of a career (Grundlingh 1993:293–294; Potgieter 1992:148).

The effect on black culture was even more profound: links with tribal land and traditions weakened and the “marabi” culture emerged. The impoverished, urban working class developed a culture associated with illegal shebeens, police raids and a jazz-style of music called “marabi”. Therefore, young people growing up in the city did not associate themselves with tribal life and customs. Their poor living conditions ultimately lead to a type of informal social unrest, in which black women played an important role. Thus, black women changed their traditionally passive role and became activists (Grundlingh 1993:293–296, 303–304).

4.3.3 Socio-political changes evident by 1948

Although urbanised black people experienced poor living conditions, their lives did improve to some extent because they earned an income by working in the war-driven industries.

Wages improved, and as the South African government needed workers, the 1937 influx-control system was suspended. Under the influence of Smuts, school-feeding schemes and pension rights for black people were implemented. This was done because it became evident that rural and urban black people were suffering from poverty and poor health. Yet it was far from the ideal life for most (Marks 1994:132).

In the words of Albert Luthuli, the 1948 general election in South Africa was “for most of us Africans ... largely irrelevant. It did not seem of much importance whether the whites gave us more Smuts or switched to Malan. Our lot has grown steadily harder

...” (Grundlingh 1993:284). The NP won the election primarily because voters deemed the “black peril” issue as very urgent: the great urban influx of black people during WW II was of concern to white voters. It also appeared as if Smuts’ Union party would not maintain a policy of segregation, which implied the possibility of white people being overwhelmed by large numbers of black people. Owing to the NP’s policy of promoting Afrikaner interest at the cost of other cultural groups, African people developed a more radical political stance (Grundlingh 1993:282–284; Mortimer & McGann 2005:114).

In 1944, the ANC Youth League, with leaders such as Nelson Mandela, Walter Sisulu and Oliver Tambo was established with a branch opening at Fort Hare in 1947. Nursing students at Lovedale College became politically more active in the 1940s. The fact that they developed a political consciousness is not accidental: Lovedale College was close to the University College of Fort Hare, where most of the ANC Youth League leaders studied and there was contact between the two groups of students. Both Lovedale and Fort Hare were missionary sponsored institutions of learning. Lovedale trained the best educated African girls while Fort Hare trained their brothers and boyfriends. In fact, when the Lovedale nurses went on strike in 1949, they were assisted by young political activists such as Robert Sobukwe who provided them with legal advice and blankets when they slept on the nurses’ home lawn (after being expelled from the nurses’ home). As president of the Student Representative Council (SRC) at Fort Hare, Sobukwe referred to the nurses’ strike in his speech of 21 October 1949 and stated that the strike was “... a struggle between Africa and Europe, between a twentieth-century desire for self-realisation and a feudal conception of authority” (Marks 1994:111). Robert Sobukwe later married one of the nurses, Veronica Mathe (Adhikari 2006:40–41; Mandela 1995:122–123; Marks 1994:107–111; Mortimer & McGann 2005:114; South African History Online [S.a.]:c).

The link between the young political activists and nurses is also made evident by Nelson Mandela in his autobiography: his first wife, Evelyn Mase, was a nurse studying at the Johannesburg non-European General Hospital. Also studying with her were Mrs Albertina Sisulu and Rose, the wife of Peter Mda (Mandela 1995:116).

4.3.4 WW II changes the system of nursing in South Africa

The need for nurses to take care of injured soldiers had a devastating impact on the South African health services. Approximately 1 100 nurses went on active duty in Europe and North Africa, which led to a severe nursing shortage in the country. Especially sister tutors were in short supply: in 1945 there were only 29 qualified and practising sister tutors in South Africa. Thus the training of nurses almost came to a complete standstill. Before the war, married women were not allowed to nurse and this in itself kept the number of available nurses low. With the great need for nurses created by the war effort, married women were allowed into the nursing fold, but to a limited extent. They were given temporary posts with lower salaries, reduced leave privileges and little chance of being promoted up the nursing ranks. Although this assisted in providing a nursing force for the country, the need for an effective training system became evident. Therefore the newly formed SANC set itself the task of organising an effective nursing training system. To this effect, a 1944 memorandum including the following proposals was presented to the Secretary of Health:

- Establish departments of nursing education in each of the Union's provinces.
- Establish nursing colleges in each province.
- Implement a training system where smaller hospitals link with central training institutions to follow a block system of training. This concept of training was also referred to as the group system.
- Train tutor sisters and establish university chairs in nursing science in order to place nursing on a tertiary education level.
- Transfer nursing training to the Department of Education (at the time it was hospital-based, apprenticeship training).
- Establish directorates of nursing in each province.
- Limit student nurses' working day to eight hours per day.
- Extend the training facilities for non-white nurses.

Some of the proposals were implemented within three years. Nursing services were separated from nursing education: the training of nurses was no longer the responsibility of nursing services. The first nursing college opened its doors at the end of 1945 and in 1947 the first organiser of nursing services, Mrs Charlotte Searle, was

appointed by the Transvaal Provincial Administration. It is interesting to note that she was a married lady (Grundling 1993:293–294; Potgieter 1992:148–149, 153–154; Samson 1978:48; Searle 1972:259).

4.3.5 The need for black nurses

Before the outbreak of WW II, the training of black nurses was discussed by the SATNA and the BTNA, but the matter was not seriously considered by the SAMC and the government of the day. Therefore the number of nurses in training was insufficient for the population it was expected to serve. To illustrate the point: in 1940 the black population in South Africa was given as approximately 7 million people. There were approximately 23 000 hospital beds available – and only approximately 200 black registered nurses (Marks 1994:91; Samson 1978:48).

With this small number of black registered nurses available, and most of the white nurses actively involved in the war effort, the need to train black nurses became imperative. The health care services for African people had to be expanded due to the effect of urbanisation on the health of an increasing population. As discussed earlier, the socio-economic conditions in the slum areas were not conducive to good health. Mashaba (1995:33) also states that the incidence of ill health increased due to people practising “harmful cultural practices” and trying to maintain a rural life style in an urban setting. It was estimated that close to the end of WW II, in 1944, South Africa had a shortage of 12 000 black and white trained nurses (Mashaba 1995:33–34; SANA 1980:30; Searle 1972:276).

The new urgency to train black nurses was created by two important factors. Firstly, the war created a shortage of nurses at a time when black urbanisation and the subsequent need for access to Western medication occurred at an increased rate. Secondly, there was political motivation in the form of the policy of separate development. White nurses were expected to work in the hospitals for white people; while black nurses were needed to work in hospitals built to serve the black community. This could only be achieved if there were sufficient numbers of trained black nurses in the country (Mashaba 1995:34; Searle 1972:278–279).

Despite the urgent need for nurses, the training of black nurses involved overcoming obstacles related to education and social customs. Although secondary school education had become more accessible to black learners, the custom of giving male children preference still prevailed as late as 1955 with only 21,1% of Standard 10 (Grade 12) learners being female in that year. Broadly speaking, literacy among African people in general was a problem after the war (1948/9): only 9 600 of five million black females had a high-school education. Of the mentioned 9 600 females, 40% of them were interested in nursing and 44% were interested in teaching as a profession. Even though there was therefore sufficient interest in the nursing profession, training facilities for black nurses were limited and only 300 posts were available to new student nurses (Mashaba 1995:34; Searle 1972:276–277).

It is against the background of black nurses being urgently needed that the pre-WW II debate regarding a less well-qualified nurse must be compared with the post-WW II discussion. Before WW II, discussions were taking place in Natal regarding the possibility of training less well-qualified black nurses. This suggestion was strongly opposed by white nurses and the SATNA. However, after WW II, when the South African Union drafted its first health legislation, the idea was supported by SATNA and the Natal Medical Council although there were objections from white nurses. Some were opposed to the lower-level of training while others were opposed to training black nurses at all. Marks (1994:92–93) states that the reasons why white nurses opposed the training of black nurses were twofold. They feared that the hard-won status of nursing will be lost. They were also concerned that black nurses would be willing to work for lower salaries, thereby taking work opportunities away from (more expensive) white nurses.

4.4 SOUTH AFRICAN POLITICS: APARTHEID AND THE POLICY OF SEPARATE DEVELOPMENT

As discussed earlier in this chapter, by the time the NP won the 1948 general election, South Africa had lived with a socio-political structure of segregation for years. However, in an effort to create a unique Afrikaner identity, Afrikaner politicians formalised this structure by means of legislation. Grundlingh (1993:267) states:

“As a cultural and political phenomenon, a specifically ethnic and narrowly defined Afrikaner nationalism undoubtedly left its mark on 20th century South African history. This is about the only non-controversial statement that can be made in connection with Afrikaner nationalism.”

Its influence on the development of black nurses will be examined, but first the phenomenon itself must be understood.

4.4.1 The beginning of apartheid

The apartheid years are described as commencing with the 1948 general elections, won by the NP, and lasting until 1994 when South Africa held its first non-racial general election, thereby bringing the ANC to power. The rise and fall of apartheid can broadly be divided into three eras described as follows (Beck 2000:126; Makgoba 2006:14):

- 1948–1959: the rise of the NP
- 1959–1970s: the heyday of apartheid
- 1970s–1994: the move away from segregation policy

The NP realised that total apartheid was not practicable because black labour was needed in the mines and in industries. Therefore a social apartheid was created by means of a series of laws. The Prohibition of Mixed Marriages Act (55 of 1949) forbade people from different cultures to marry; the Population Registration Act (30 of 1950) classified South Africans into groups of white, black and coloured persons; the 1950 Group Areas Act (41 of 1950) ensured residential separation based on race, and the Industrial Conciliation Act (28 of 1956) created industrial tribunals which ensured that certain types of work were reserved for white people (Samson 1978:48; Scher 1993:322–324).

When HF Verwoerd was appointed *Minister of Native Affairs* in 1950 he advocated total racial segregation and the belief that black people had to develop and govern themselves separately from white people. He did not regard black people as permanent urban residents and therefore introduced bills to keep them in designated areas. The Natives Act (54 of 1952) was implemented to control the influx of black people into the cities. For the first time, African women also had to carry “passes” (a

book allowing them to travel outside the boundaries of their designated area). The Act was amended in 1956 so that black people were only allowed to remain in proclaimed (white) areas for 72 hours at any given time, unless they had a permit stating otherwise. Their permits to stay longer elapsed when their employment was terminated. By law, the only black persons who were allowed to stay in urban areas were those born there; those who had lived continuously there for 15 years, or those who had worked continuously for the same employer for at least 10 years (Scher 1993:346–248).

When Verwoerd was elected Prime Minister in 1958, he changed the name of the Department of Native Affairs to that of Bantu Administration and Development. At this time, other countries in Africa were gaining their freedom and independence. It was the start of African nationalism. Verwoerd's reaction to this was to offer black people so-called 'homelands' which eventually would become politically independently governed territories but economically interdependent. He did this by means of the *Promotion of Bantu Self-Government Bill* 46 of 1959 which aimed to develop eight national homelands. Urban black people were expected to link with one of these homelands (Scher 1993:355–357).

4.4.2 Black South Africans react to the system of apartheid

Black South Africans protested against the apartheid laws by means of the “defiance campaign” which started on 26 June 1952. Three years later, on 26 June 1955, the Freedom Charter was drawn up. African women played an important role in the protest actions of the 1950s; the most notable contribution being the 20 000 women who marched to the Union Buildings on 9 August 1956 to protest against the carrying of passes. After years of protest and political unrest, the turning point for apartheid policy came after the events of 1976–1977 which included the Soweto uprisings. The integration process started in 1983 when South Africa adopted a new constitution and a three-tier parliament. By 1988, political changes to the apartheid system were urgently needed for the country to recover and prevent total meltdown. This meant that the NP government as well as the ANC had to consider changes to their political viewpoints (Beck 2000:162, 165–180; Scher 1993:378–379, 383).

4.4.3 The influence of apartheid on the development of the nursing profession

Ironically, apartheid created circumstances which greatly stimulated the professional development of African registered nurses. Owing to the apartheid government's policy of separate development, hospitals were dedicated to care for patients based on their ethnicity: black persons in one hospital and white persons in another. There was also a drive to implement the same principle with regard to nursing staff. White nurses were gradually removed from so-called non-European hospitals and they needed to be replaced by trained black nurses. Suddenly the need to train black registered nurses and nursing managers became so urgent that posts were created to which only black nurses could be appointed (Cheater 1974:156–157; SANA 1980:25; Searle 1972:278–279).

The growth in the numbers of trained black nurses is evident from statistics provided by Searle (1972:279) regarding the Transvaal hospital services. In 1950, there were no black matrons (nursing managers), no student midwives, and only nine registered black nurses in service. By 1960, these numbers had changed significantly: there were 13 matrons, 100 student midwives and 1 137 registered black nurses in service. Although the numbers seemed impressive, one must take into account that it had taken 10 years to reach this number and it was in only one province of the country. By 1974, the ratio of qualified (registered) nurses in relation to the population of the country as a whole (South Africa *and* South West Africa/Namibia) were 1:1 111 for black people in comparison to 1:175 for white people (SAVV 1975:10).

4.5 SOCIOCULTURAL FACTORS INFLUENCING THE ENTRY OF BLACK PERSONS INTO THE NURSING PROFESSION

Although WW II and the policy of separate development stimulated the need for trained black nurses, there were still educational, social and cultural barriers to overcome.

4.5.1 The number of black girls receiving secondary education during WW II

Progress in the training of black nurses was evident after WW II, but it was slower than desired, mainly because black student nurses were still hampered by the English language of instruction, the inferior secondary education they received, and the cultural influences which still gave preference to young men when it came to choices in education. Most parents of young girls chose not to keep them in school until they matriculated (passed Grade 12). They were taken out of school once they had passed Standard VIII (Grade 10) because, with this level of education, they could enter nursing or teaching. This assisted the families, because the girls could start contributing to the home earlier. Shortly after the war, in 1946, the Transvaal province had only 660 black girls in Standards VIII to X (Grades 10–12). After WW II, South Africa had only 1 500 black girls in Standard VIII (Grade 10) (Mashaba 1995:71; Searle 1972:276, 279; South African Information Service 1961:11). The low number of girls in high school can be explained in terms of the socio-economic and political conditions of the era.

4.5.2 The socio-economic and health status of black people: 1950s–1970s

The 1950s–1960s witnessed a great expansion in the size of the black population. By 1975, it was calculated that 71,3% of the South African population was black. With this expansion of the population came major changes in their distribution throughout the country. Urbanisation increased at a tremendous rate so that 31,8% of the black population lived in cities by 1960 (this in comparison with 21,6% in 1946). It was exactly this influx of people that created concern in politically minded white people and motivated the expansion of the policy of separate development. Homelands were established in Transkei (1963), Bophuthatswana, Ciskei, Venda, Qwaqwa, KwaZulu and Gazankulu (1972–1977). It was envisioned that these homelands would be self-governed areas, but in the 1960s it became evident that the homelands were in a state of economic collapse. Yet, despite the economic difficulties, the population increased by 70% as more than 3,5 million black people were relocated to the homelands over a period of 25 years. The Bantu Labour Act (67 of 1964) prevented black men from moving their families away from the homelands, which resulted in the phenomenon of migrant workers. The men had to move to the cities to find work, while the women remained behind in the economically poor homelands to care for the children (Beck 2000:151–153; Mashaba 1995:47, 62).

The increase in the black population, their specific distribution in the country and prolonged contact with the Western life style, brought changes in black people's socio-economic and health status. Since the 1950s, illnesses such as smallpox, bilharzia, diphtheria and tuberculosis became a major threat. Malnutrition and gastroenteritis led to a very high infant mortality rate. Social crimes such as assault increased. At the same time, black people started to value the benefits of Western health care, which put pressure on the health services to expand. An American nurse who visited Baragwanath Hospital in 1970 was told that the parents brought their children sooner to the hospital because they had received health education and were therefore able to recognise dehydration caused by diarrhoea sooner. The Baragwanath nurses also confirmed the notion that black people were starting to gain confidence in Western, scientific medication (Beal 1970:548; Mashaba 1995:47–48, 62).

It is interesting to note the complexity of the factors that led to a greater demand for black trained nurses. Firstly, WW II necessitated the need for more nurses and contributed to the conditions which led to greater urbanisation. Secondly, the political policy of separate development created homelands and racially segregated hospitals. Thirdly, the largest South African population group began trusting Western medication, which stimulated the demand for more hospital beds and therefore more nurses. Yet also of importance in this cycle of demand and supply was the role of the black trained nurses themselves. Marks (1994:11) states that patients from non-Western cultures accept Western medication more readily if it is explained to them by nurses from their own culture. The patient can understand the language used and the nurse understands the patient's cultural background. From this the researcher deduces that the presence of black nurses in hospitals motivated black patients to seek help, which in turn necessitated the need for more black nurses. Finally, during this era, black women had only two professional career options: nursing or teaching. This statement is confirmed by Mashaba as quoted at the beginning of this chapter.

4.5.3 The social status of black nurses in South Africa: 1950s–1970s

Cheater (1974:143–145) states that the social status of trained African nurses in Durban had major recognisable implications. They were considered as an elite class with an “occupational identity”. This occupational identity was created by restrictions on admission to the elite group: only persons with a Standard X (Grade 12) and matriculation exemption for a university degree were admitted to the nursing course. Even after admission, the candidates also faced barriers to admission into the profession because they then had to pass the three-year training period, write the final examination and be registered at SANC.

The Western-styled training and lifestyle had a major influence on African nurses’ social perceptions and position in the greater society. They had to adapt to a culture and a health care system which was very different from the traditional African culture and health care methods. Therefore, the African nurses gradually rejected the traditional, “slow country life” described by Beal (1970:550) and identified with the Western life style. They limited their contact with their non-elite family members, even though they continued with the responsibility of supporting elderly parents and younger siblings (Cheater 1974:144–145, 152–153; Marks 1994:12; Mashaba 1995:60–61).

In their own homes, the black nurses conducted themselves very differently from the lifestyle in the households they had grown up in. By the 1970s, black nurses were viewed as an elite class and displayed their exclusiveness by means of leisure activities such as ballroom dancing and embroidery. These ladies were the innovators of fashion. In their homes they employed domestic workers to whom they taught topics such as child care, diet and hygiene. Therefore they created new norms and values with which the society they lived in had to comply. The nurses’ elitist life style made them attractive marriage partners and therefore men who wished to move into the social upper-classes often married nurses. In the words of a Reeftown resident in Durban: socially “a wife can pull her husband up” (Cheater 1974:143, 158, 151).

Within the nursing profession, African nurses, especially the older married nurses who held senior nursing positions, were also aware of their educated class. They expressed it by means of participation in professional organisations such as the SANA (membership fee R6,00) and other voluntary associations such as the Young Women’s

Christian Association. African nurses became socially exclusive and private. However, their exclusiveness did not prevent them from caring for society. They often used their membership to pressure the apartheid bureaucracy into action and became known as “instigators of change” (Cheater 1974:147). For example, at the 1970 SANA Biennial Congress, resolutions were passed which benefitted Africans socially (Cheater 1974:144–149; Mashaba 1995:60–61).

- The rules regarding the repossession of the homes of widowed or divorced nurses should be relaxed.
- A centre for the treatment of alcoholics and drug addicts must be established.
- The establishment of crèche facilities should be established for the children of health care workers.
- Compulsory education should be free for all so-called non-white children up to Standard VI (Grade 8).
- Tax rebates to African people who support dependants.

The researcher deduces from the abovementioned achievements that African nurses gained a certain measure of political power despite their formal powerlessness.

However, not all was smooth sailing. African nurses were allowed to be members of professional organisations such as SANA and SANC, but they had no voting rights and although they completed the same nursing course as their white counterparts, there were differences in working conditions and salaries. In greater society, they also faced obstacles in the form of the apartheid laws mentioned earlier in this chapter. Their work was influenced by the Natives Act of 1952, which controlled the influx of black people into the cities – which was where the larger training hospitals were. Thus, the black nurses lived far from their place of work and travelled great distances between home and work. They also experienced cultural conflict: leaving home to do nursing meant that they had less time for the traditional female role which required of them to perform the household duties. African men traditionally did not perform household tasks and therefore the burden on the nurse and the potential conflict in the marriage increased (Cheater 1974:144–145; Van der Merwe 1999:1273).

4.5.4 The married nurse

Before WW II, the nursing profession consisted primarily (and traditionally) of unmarried women. Married women had to enter the nursing field due to the war's demand for nursing care of injured soldiers. This trend continued and by the 1970s, 66% of the nursing corps was married women. Therefore they came to play a major role in the profession. This was recognised by SANA and other nurse leaders such as Charlotte Searle, who stated that the profession needed to start considering the educational and work-related needs of married women (SANA 1980:57–58; Searle 1975:57; South African Information Service 1961:10).

African women had a number of cultural barriers to overcome. A 1949 report of the National War Foundation identified reasons why African high school girls did not want to take up nursing. The socio-cultural reasons were numerous, including the fact that most girls reached a marriageable age before completing high school. One school girl who was interviewed stated that parents did not wish unmarried women to nurse men. Other girls explained that Western-style hospitals were not familiar or trusted institutions among African people and therefore young women also did not consider nursing as acceptable. Added to this belief was their fear of blood and dead bodies (University of Witwatersrand 1949:15).

In general, African married women had problems related to their social status as well as their adopted Western norms and values. Nurses were considered as belonging to a high social status; often higher than their husbands even though most of the men had a better secondary education than their wives. The reason for this can be found in the nature of admission to the nursing profession. Until the 1970s, a Junior Certificate was sufficient to allow entry into the nursing profession. Once black women entered the Western hospital world, they adopted (to a certain extent) Western values and norms, which was not in accordance with their husbands' more traditional philosophy and life style. Tension in the marriage was almost inevitable. There were exceptions to the rule: Mashaba (Mhlongo 1998:76-77, 97) described her husband as being supportive of her studies even when his family voiced their opposition. But this support had its limits. Like most married women, Mashaba chose family before career and thus resigned from a teaching post in order to move home and join her husband. For a number of years, she was a married nurse, raising three children. It is noteworthy that her academic

career only commenced in 1975, after the death of her husband (Cheater 1974:153–156).

4.5.5 The financial status of black nurses in South Africa: 1950s–1970s

From a socio-political point of view, African nurses were placed in a marginal position by the apartheid policies of the time. Professionally, they were considered an elite group, but even in this role they experienced limitations. Although their salaries were high in comparison to those of women in other jobs, they still received a smaller salary than their white counterparts who had completed the same training. Searle (1972:372) argues that the smaller salaries were based on the perceived differences in cultural standards and the fact that housing and transport for black people were subsidised. An African nurse received 60% (three-fifths) of a white nurse's salary (Cheater 1974:157; Marks 1994:136–137; Mashaba 1995:60; Mortimer & McGann 2005:121; Searle 1972:372).

4.6 SECONDARY BLACK EDUCATION IN APARTHEID SOUTH AFRICA

The duality of apartheid policies is clearly illustrated in their management of secondary education for black children, and its subsequent effect on the availability of suitable nursing candidates.

4.6.1 Secondary black education 1950s–1970s

In terms of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) definition of literacy (four years of education), 60% of the black population in South Africa was considered literate by 1973. Studying the educational level of African students, Searle (1972:300) stated that there was almost no increase in their educational standard during the years 1952–1960, with only 10% of black student nurses possessing a Standard 10 (Grade 12) qualification. She maintained that this matter should be addressed if South Africa wished to produce a high-standard black nursing cadre (Hartshorne 1974:2519).

The Bantu Education Act (47 of 1953) enabled more children to attend school, but the influx of a larger number of learners was not matched by a larger number of qualified

teachers (by the 1970s, 35% of black teachers were doing work they were not trained for). The teacher-student ratio increased from 1:42 in 1946 to 1:61 in 1965. Despite this increase, school funding was not increased. At the same time, the apartheid government intensified the influx-control measures which were already in place. Women were allowed into the city with a visitor's permit only; unmarried women (black and white) were not granted housing; and from 1962 to 1971 no new secondary schools for black students were built in urban areas. These measures forced black women and children to move to the homelands, while creating poor classroom conditions in existing black urban schools. It was only in 1972 that new schools were built in Soweto, one of the largest townships in South Africa, and only in 1979 did Education and Training Act 90 make tuition for black children compulsory and free. Yet, little of the Act was implemented and black parents opposed the Act on political grounds as they wanted an integrated, non-racial educational system (Baloyi 2004:92–97, 122–124; Bonner 2006:35–38; Hartshorne 1974:2517–2518; Mashaba 1995:48, 64; Scher 1993:326–327).

The effect of this inadequate schooling system was evident in the numbers: although 70% of black children attended school by 1973, few of them obtained a matriculation certificate (Grade 12) which allowed them entry into universities. In 1972, only 1800 learners obtained a university-entrance matriculation pass, while a further 1100 obtained the senior certificate. In fact, black matriculation results declined in the period 1948–1976. The Director of Education Planning in the Department of Bantu Education mentioned the barriers to obtaining educational goals in a 1973 speech. He cited issues such as the high population growth, lack of finances, the slow growth in the number of trained teachers, and the politics of separate development. More than half of black learners lived in the homelands and were therefore under the control of the homeland departments of education (Baloyi 2004:102–103; Hartshorne 1974:2517–2518).

Although the policy of separate development stimulated the growth of black professional nursing, it may be deduced that the apartheid government's drive to implement the policy of separate development also created a barrier by keeping young black women from urban areas where the large nursing training hospitals were situated (note discussion in sub-section 4.7.1). Consequently, the need for a large number of professional black nurses was undermined by measures of influx control and the

ineffective secondary school education. The apartheid government created a situational duality: on the one hand they required a large group of professional black nurses in order to implement racially segregated hospitals, but at the same time their educational apartheid policies hampered the growth of professional nursing by not providing effectively trained matriculants in sufficient numbers.

4.6.2 The effect of the Bantu education system on nursing

The notion that African nurses lack intellectual ability was proven wrong in the 1970s when research revealed that the main problem was not intellectual ability, but rather the fact that African nurses were taught in a language that was foreign to them in a sense. Not only were they required to master a new language, but they also had to learn Western concepts of health care, which were culturally alien to them. The nurses who overcame the language barrier were those with a higher secondary education: Standard X (Grade 12) (Mashaba 1995:34–36, 71).

Large numbers of black nursing students who commenced training in the 1940–1950s did not complete their training. Owing to their inadequate secondary education (especially the lack of science and English language training), 33% of black nursing students annually did not perform academically and were lost to the profession. A further 15% were lost due to pregnancy (Mashaba 1995:34–36; Mhlongo 1998:136, 149).

The problem became so serious that in 1949 the National War Memorial Health Foundation compiled a report analysing the position regarding young females in Bantu, Coloured and Asiatic (non-European) secondary schools. It was found that the school syllabus allowed a variety of subjects; consequently, nursing candidates often commenced their training without ever having completed any science subjects. Furthermore, the cultural practice of leaving school at an early age became evident: only 191 non-European girls completed Standard 10 (Grade 12) in the Union of South Africa. A staggering 2 405 of them left after completing Standard 8 (Grade 10). Statistics confirmed that there were girls as young as thirteen who entered the nursing profession. The National War Memorial Health Foundation report advised that the age of 17½ should be made the minimum requirement for entry into nursing (University of Witwatersrand 1949:3, 6).

The National War Memorial Health Foundation committee further probed the career choices available to black girls leaving secondary school. It was found that the two professional careers available to them were nursing and teaching, with teaching being the more popular choice. The committee also asked the principals of secondary schools to state the reasons why young black girls did not consider nursing as a career choice. The answers were as follows (University of Witwatersrand 1949:8, 10–15):

- The long training period, rigid discipline, and the strenuous work involved scuttled interest in the profession (the report states that the health of non-Europeans was deteriorating).
- A distinct preference for teaching prevailed because teachers received a higher salary and had a higher social standing than nurses.
- The lack of nursing training facilities close to girls' homes also discouraged interest.
- The educational entry requirements for nursing were too high.
- Superstition and custom made the girls wary of the Western hospital with its dead bodies and blood; in addition, the girls' parents also believed that unmarried women should not nurse men.
- Most girls had little or no information about nursing salaries, conditions of work or the availability of training facilities because no marketing was done to promote the profession.

4.7 SANC INFLUENCE ON NURSING REGISTRATION AND TRAINING

“... there shall be established a council to be known as ‘The South African Nursing Council’ ... The head office of the Council shall be situated at Pretoria ...” (South Africa 1944: lxiv).

South African nursing became professionally independent with the promulgation of Nursing Act 45 of 1944 on 6 June 1944. It granted South African nurses statutory control of their profession and made registration of qualified nurses and midwives compulsory. It also transformed the SATNA into the SANA and marked the end of the BTNA because membership of SANA was compulsory for all registered nurses,

midwives, student nurses and student midwives – regardless of race (Marks 1994:123, 132; Potgieter 1992:149; Searle 1972:275).

4.7.1 SANC legislation in the 1940s

The Nursing Act (45 of 1944), Part I and Part II, made provision for the establishment of a Nursing Council which consisted of 24 members including 2 doctors, 10 elected nurses, 3 elected midwives and one nurse elected by students. The power of the Council is described in 15 sections of the act and included control over the examination and registration of nurses, the keeping of the registers, the writing of nursing regulations, and the council's disciplinary role. The registration conditions and the keeping of the register are explained without any mention of race or colour. The Act simply states that all nurses registered with the SAMC will be considered registered under this new Nursing Act (South Africa 1944:lxiv–lxx).

Part III of the Nursing Act (45 of 1944) makes provision for the transformation of the SATNA into the SANA and for all SANC members to become SANA members as well. The Association was tasked with managing the SANA branches, producing a nursing journal, establishing a pension fund for nurses, and improving the conditions of service of nurses. Interestingly, the Act requires the head office of SANA to be in Cape Town while it requires the head office of SANC to be in Pretoria (Marks 1994:123, 132; South Africa 1944:lxx–lxiv).

As discussed in sub-section 4.3.4 of this chapter, nursing training in South Africa during WW II almost came to a standstill. Therefore it was the task of the new nursing council to establish an effective system of nursing training in South Africa. To this effect, it was proposed that provincial departments of nursing education, under the control of the Union government, be established, with nursing colleges close to all the large hospitals in the large urban areas. SANA proposed that nursing training should not be considered a provincial issue, but rather a national issue. This proposal was discussed at a 1946 conference, which was attended by delegates from SANA, the Ministry of Health, the Union government and provincial authorities. The proposal was rejected by the Department of Health. The department argued that, since it was the provincial authorities that mostly trained and utilised the services of nurses, the financial burden should also be theirs (Searle 1972:291–292).

Thus, for the time, nursing training remained a provincial affair. SANA continued to focus on the need for trained nurses and to this effect the provinces of the Cape, Transvaal and Natal passed provincial regulations in 1948 which replaced the traditional hospital certificates with an Auxiliary Nurse certificate for African students. Nursing Act 69 of 1957 later made provision for these auxiliary nurses to be enrolled at SANC. The nursing profession debated the issue of a less well-trained nurse being registered at SANC, but Searle defended the decision by stating that statutory control of qualified and less qualified nurses gave the profession control over them and by so doing kept the public safe. She was also of the opinion that nursing units could not be managed by registered nurses and student nurses only – a nursing category between the two was needed. It is not possible to establish exactly how many black nurses were enrolled or registered in the 1940s because SANC statistics indicated numbers of non-white nurses which included black, Indian and coloured persons (Mashaba 1995:33; Samson 1978:48–49; SANA 1980:15–16; Searle 1972:279).

In general, SANC influenced the basic nursing courses by addressing issues such as the content of the curriculum, the length of training provided and the establishment of new nursing courses such as the enrolled nursing auxiliary and a course in psychiatric nursing care (Samson 1978:48–49).

4.7.2 SANC legislation: 1950s to 1960s

SANC continued its task of improving nursing training in the country. The first training school for black nurses in the field of mental-health nursing opened its doors in 1956, but unfortunately the course was discontinued in 1968 by the Department of Health. In 1953, new regulations required nursing candidates to have Standard 8 (Grade 10) for admission to nursing courses. It was also practice that newly qualified registered nurses were known as “staff nurses” (today’s “enrolled nurses”). They were then gradually promoted to the senior position of “sister” (today’s “registered nurse”) (Mashaba 1995:49; Potgieter 1992:154; Samson 1978:49).

In the 1950s, and even as recently as the 1960s, few professional career opportunities were available to black women. In fact, the choice was between nursing and teaching. Therefore the availability of potential nursing students was abundant and little

recruitment was required. Yet, most candidates were not accepted for training due to their inadequate secondary school education. Also, few nursing student posts were available; for example, Baragwanath Nursing College received 2 000–3 000 applications for training but had only 250–300 nursing student posts available. By 1959, the actual number of black nursing students was lower than expected and prompted SANC to appeal to the government to increase the training of black nurses. The 1960 SANA Congress for Bantu members also expressed their concern regarding the state of the Bantu education system and, in 1962, expressed the need for more training schools for black nurses. It must be remembered that this situation coincided with the period in time when apartheid was well established and actively driven by the government. In the 1940s to 1950s the state was also more involved in the politics of nursing (Beck 2000:125–126; Marks 1994:12; Mashaba 1995:50–52).

Therefore, the 1950s will be remembered as the period when the racial division of South African nurses was formalised by means of Nursing Act 69 of 1957. Based on the Population Registration Act (30 of 1950), the first page of this Nursing Act states the definitions of white, coloured and native persons (no specific reference to Indian persons are made). It also requires the keeping of separate rolls and registers of qualified nurses, based on their race. Nurses were given one year to provide SANC with details regarding their race. Thereafter they were de-registered and would not be allowed to vote in Council or Advisory Board elections. This was actually a moot point, because the greater threat was that a de-registered nurse would not be allowed to work in the health care sector (South Africa 1957:1, 10, 12, 14, 16).

The Act even prescribed that uniforms and distinguishing devices must be different between the races. Coloured and native nurses were given six months to hand in the “incorrect” distinguishing devices in their possession. They were refunded for it (South Africa 1957:10, 12).

The Nursing Act (69 of 1957) dictated the election of the SANC Board and the establishment of Advisory Boards for Coloured and Native nurses. It stated that only white SANC members, registered nurses, midwives and student nurses, had voting rights. This would ensure that only white persons were voted onto the SANC Board, but as a precautionary measure it was also written into the Act (point no 4) that any open vacancy on the Board had to be filled by a white person. The only representation

allowed for non-white persons were one “native” and one coloured person who were elected by their Advisory Boards; not the general SANC membership. The election of the SANA Board was conducted on similar principles (Cheater 1974:145; Mashaba 1995:56–57; South Africa 1957:4, 6, 16, 24).

The SANC Board’s control over the Advisory Boards is also evident in the Act. The election process for membership to the Advisory Boards was managed by the SANC Board. Coloured registered nurses voted for members of the Coloured Advisory Board only. Native registered nurses voted for members of the Native Advisory Board only. Once elected, the Advisory Boards met once per year at a time and place decided by SANC (The SANC Board met twice per year). This meeting was also attended by SANC Board members who had an advisory role but no voting rights. Financial assistance for the Advisory boards was provided by SANC (South Africa 1957:6, 8, 16, 18).

The influence of the policy of separate development is evident in Nursing Act 69 of 1957. The researcher notes that the Act created opportunity for interference by apartheid policy into the quality of daily nursing care rendered to patients. The Nursing Act (69 of 1957), Part V no. 49 states that:

“Any person who, except in cases of emergency, causes or permits any white person ... to be employed under the control or supervision of any registered or enrolled person who is not a white person, in any hospital or similar institution or in any training school, shall be guilty of an offence and liable on conviction to a fine not exceeding two hundred pounds.”

This implied that a white first-year nursing student had more power than the black registered nurse in charge of a nursing unit (South Africa 1957:30).

Black nurses reacted to these inequalities with dignity. Alina Lekgetha, the first Chairman of the SANA Advisory Committee for black nurses, stated in 1960: “... you are not a politician you work in a political milieu”. She therefore strongly opposed the Nursing Act (69 of 1957), but also believed that the racially separate SANA branches and committees would afford black nurses the opportunity to perfect their skills of managing and organising a professional association. She strongly believed that the

patient's needs came first and she therefore opposed notions of strike and violence (Sweet & Digby 2005:121–122).

4.7.3 SANC legislation in the 1970s

The SANA commented in their 1978 nurse training report that the period 1974–1976 was one of consolidating basic nursing education. This was due to new training regulations related to general nursing, midwifery and psychiatric nursing. As in previous decades, SANC continued its task of establishing a nursing training system of high quality, which would confirm the message that nursing is a science and an art. To this effect, the nurse's scope of practice was defined, nursing course content was made more scientific, and the entry level for nursing training was raised from 1944s Standard VIII (Grade 10) to Standard X (Grade 12) in 1960. However, until 1978, this requirement was not strictly enforced and it became general practice for matrons to use their discretion in allowing candidates with less education to commence training. The system of preliminary examinations was abandoned with the last preliminary examination written in 1976. Thereafter, the practice of annual examinations was implemented (Mashaba 1995:65, 72; Samson 1978:48; SAVV 1978:2–3).

Major changes were also made in SANC legislation. By making provision for the abolition of the SANC Advisory Boards and the establishment of separate nursing councils (and associations) in the independent homelands, the new Nursing Act (50 of 1978) created a multi-racial SANC. Although it was the first time that black nurses were allowed direct participation in nursing affairs, one could hardly describe the South African nursing profession as united. The 1970s was a politically volatile period in the history of the country and, with that in mind, Nursing Act (50 of 1978) declared strikes by nurses unlawful (Mashaba 1995:66, 78–79).

By the 1970s, SANC and SANA had been leading the South African nursing profession since its institution 30 years previously. The question arises: how did they progress in establishing a nursing training system of quality? And how did they progress in providing the cadre of black trained nurses required to care for the black South African population?

4.7.4 Black nurses available in South Africa by 1975

“This country does not know how many professional nurses it needs, because nobody really knows what the health needs are. I am tempted to say that we are an unhealthy lot” (Searle 1975:36).

Searle (1975:36–37) states that the number of nurses needed in a country is dependent on the health needs of the community it aims to serve. She contends that the South African community is socially disorganised and that violence, alcoholism, drug abuse and contagious diseases place a heavy burden on the shoulders of health providers such as nurses. The question arises as to how many nurses were actually needed. The 1944 “ideal ratio” of 1 nurse to every 500 persons of the population is in her opinion a random figure chosen without any scientific basis. By 1974 SANC reported the non-white qualified nurses vs. population ratio as 1:1 111. When interpreting this ratio, one must remember that the recorded population and nursing numbers reflect the status in South Africa as well as in the territory of South West Africa (Namibia). Also of importance is the fact that the word “non-white” refers to black, coloured and Indian people. Still, it did not reflect the accepted 1:500 ratio and therefore the need to increase the training of black nurses trained was imperative (SAVV 1975:3–6, 9–11, 19; Searle 1972:264).

Comparing the South African nurse-to-patient ratio with international trends is challenging because internationally nurse population ratios are not expressed in categories related to race. Therefore, when comparing international and local South African statistics, one must bear in mind that the international statistics include nurses of all races. As this dissertation deals with the professional development of black nurses in South Africa, only the black nurse to population ratios are stated. That said, in the early days of nursing, Britain managed to have a nurse-to-patient ratio better than 1:500. In fact, Florence Nightingale indicated that the ratio in 1851 was 1:381. This ratio changed to 1:144 by 2007 and therefore the researcher concludes that British training and retention of nurses kept up with the growth of the population. The USA had similar success. A nurse patient ratio of 1:229 (436 per 100 000) was reported for the 1970s. The ratio changed to 1:157 (638 per 100 000) in the 1980s and to 1:139 (720 per 100 000) in the 1990s (Bigbee 2008:1; Hurst 2009:15).

4.7.5 Black nurses being trained in South Africa by 1978

SANA published a report on the state of nursing training in 1978. Although comprehensive statistical data is presented, the report in general is vague about the training of black nurses. For example, Table I in the report gives the numbers of SANC-approved basic-training centres for white, coloured and black students. According to the table, there were no training schools offering degree or diploma courses in general nursing to black students in 1978. Yet, as early as 1963, Baragwanath was recognised as a training school, but it seems not to be included in the 1978 SAVV report. In contrast, Samson (1978:49–51) states that there were 71 approved training schools for non-white general student nurses and 60 schools for midwifery training (Mashaba 1995:34, SAVV 1978:1). One might deduce that most of these nursing schools were not recognised with SANC, but then why would Samson refer to *approved* (by whom?) schools and why would the SAVV report include the student numbers represented in table 4.1 of this dissertation?

That training of black nurses did take place is evident from the second table of the 1978 SAVV report which indicates the number of black student nurses and student midwives (excluding university students). The numbers are reproduced in table 4.1 below.

Table 4.1 Total national number of black student nurses and midwives (excluding university students) 1974–1976

Student category	1974	1975	1976
General nurse and Midwife	15	95	449
General nurse	3 838	3 911	4 151
Midwives	1 173	1 006	1 133

(SAVV 1978:4)

The report noted that the number of basic nursing students had slightly increased, but it expressed concern that there were too few Indian nurses available to care for the Indian population. Oddly, there is no similar discussion in the report about black nurses. The only comment about black student nurses was that, due to the large number of applications for nurse training received; academically weak black candidates

were eliminated before SANC registration occurred. According to the report, there were no black nursing students registered for university degree or diploma courses. It follows that a large number of nursing candidates were excluded because they were expected to have the same educational standards for entry as their white counterparts. It appears that despite the black candidates' educational disadvantage, the standards of training were constantly raised (Marks 1994:6; SAVV 1978:4–6).

The question as to how black nurses overcame the obstacles of educational disadvantage and apartheid policy is partly explained in the second half of the 1978 SAVV report. South Africa had 130 *hospital-based* nursing schools for black, coloured and Indian students. Therefore large numbers of black nurses were trained as nursing assistants. In 1976 alone, there were 2 171 nursing assistants on the SANC roll and an additional 1 381 completed their training. For those who were trained as enrolled nurses: regulations R1570 (12 August 1977) and R879 (2 May 1975) enabled them to enrol for the course leading to registration as a general nurse. Therefore, until 2 November 1980, candidates who were not matriculated could gain access to registered nurse training. This is significant if one considers that of the 1 432 black student nurses who studied in 1976 only fifteen (15) had a matriculation qualification. These numbers were stated in the 1978 SAVV report and refer to nurses who were actively studying. However, another source provides different numbers for the same period: Samson (1978:50), Head of the Nursing Department at the University of the North, calculated the statistical data for 1976 first-time black registered and enrolled general student nurses. She states that there were 1 442 nurses in this category of whom 655 (45, 4%) had Standard X (Grade 12) (SAVV 1978:12–14).

To explain the statistical discrepancies between the 1978 SAVV report and Samson's article an in-depth analyses, not in the scope of this dissertation, is required.

4.8 THE POLITICS OF NURSING

WW II brought more white women into nursing. Unlike the black nurses, who came from an educated social background, the white women were from the middle class. In Marks' (1994:9) opinion, the new Nationalist Party government had to make nursing more acceptable to white women by removing any notions of tasks such as cleaning and scrubbing floors that were usually expected from black domestic workers. The

ruling party achieved this by encouraging the development of an elitist profession controlled by a professional body in the form of SANC. In order to be acknowledged as a profession, this newly established professional body had to set standards and it did so by means of setting high educational entry requirements and establishing academic nursing departments. In Marks' opinion, it also fitted well with the policy of segregation, ensured white control of the new profession and prevented black nurses from developing an own professional identity. However, it must be taken into account that the first nursing legislation, Nursing Act (45 of 1944), did not contain any reference to race or colour. All nurses registered with SANC and SANA was allowed to vote in SANC and SANA Board elections and in this manner controlled the development of the profession. It was only in 1957, that white control and the issue of racial segregation were introduced into the nursing profession. Ironically, it was exactly the drift to segregation that stimulated the growth of the black nursing profession because large numbers of nurses were needed to care for the large black population of South Africa (Marks 1994:5–6, 9; Mashaba 1995:48–49; Searle 1972:233; South Africa 1944:lxiv).

4.8.1 The effect of *Nursing Act 69 of 1957*

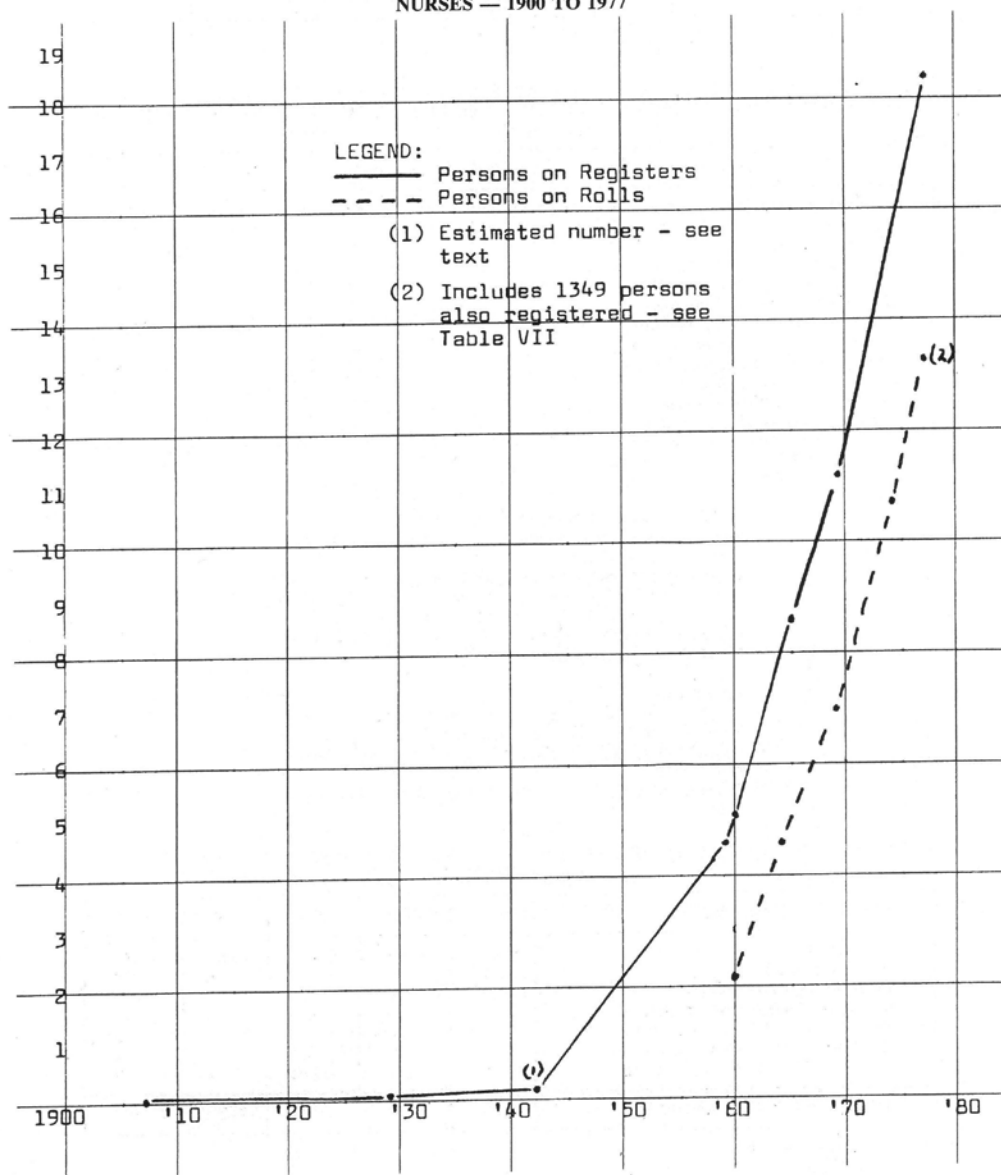
The most compelling evidence of how the politics of separate development influenced nursing is found in the 1950s. During the first decades of the apartheid era, the government, with a cabinet consisting of only white men, tightly controlled all aspects of South African society. This control was formalised by means of a series of laws such as the following: Public Safety Act (3 of 1953), Bantu Education Act (47 of 1953), and Nursing Act (69 of 1957). Nurse leaders opposed the segregation of the SANC registers, but there were others who supported the concept. Those (black and white) nurses who voiced their objection realised that apartheid was influencing the practice of nursing. They asked themselves how nurses could declare that all patients should be given equal treatment, yet among nurses themselves there was evidence of discrimination based on race. They formed the Federation of South African Nurses and Midwives and protested against Nursing Act (69 of 1957). In this they were successful because their existence and political ideology precipitated changes in the Act. However, as an organisation they were less successful and their existence was short-lived. The official explanation for the segregation statements in Nursing Act (69 of 1957) were given in a 1961 supplement to the Digest of South African Affairs. It explained that registering nurses based on race provided an accurate calculation of

nursing resources in a community, assisted in the election of representatives of each race group to the SANC and SANA Boards, and it facilitated the establishment of Bantu and Coloured special advisory committees (Beck 2000:125, 129–130; Marks 1994:8, 100; Mashaba 1995:49–50). It can be deduced that these examples, as well as the SA Prime Minister's refusal to give consent for a multiracial national conference to discuss nursing education in the country, was evidence that even the white nurses in control of nursing were subject to the rules of a strongly patriarchal society.

It is significant that, although SANC statistics were presented based on racial categories, separate registers were never kept. The statistics which were kept in this manner were used by nurse leaders to convince the government that there was urgency required in the business of training black South African nurses. In 1959, there were 22 690 qualified professional nurses in South Africa. Of this number, 4 633 were black in comparison with the 17 164 white and 903 coloured professional nurses. There were only 2 779 black student nurses in training, thus illustrating that in the early years of the apartheid era there were still relatively small numbers of black professional nurses. By 1975, the numbers of black nurses had increased significantly. There were 15 650 registered, 10 721 enrolled and 14 521 assistant nurses in the registers and on the rolls of SANC. This growth in numbers, graphically represented in Figure 4.3, seems to confirm the statements of authors such as Marks, Mashaba and Searle (mentioned earlier in the chapter) that the apartheid policy of so-called separate development stimulated the growth of black professional nursing (Marks 1994:9; Mashaba 1995:50; SAVV 1975:6; Searle 1972:278; South African Information Services 1961:5).

Figure 1 represents growth in registrations and enrolments up to 1977

**FIGURE 1:
PROGRESSION, IN THOUSANDS, OF
REGISTRATION AND ENROLMENT OF BLACK
NURSES — 1900 TO 1977**



Page Fifty-Two

**Figure 4.3 An example of a schematic representation of the growth of African nurses
1900–1977
(Samson 1978:52)**

4.8.2 Homeland nursing

The principles of appointing black nurses in senior positions and training them in post-basic speciality fields were already accepted and implemented in the 1960s – in line with the policy of separate development. In an effort to increase the number of trainees, candidates were granted paid study leave, received state subsidies and SANA bursaries. The reorganisation of the national health services to accommodate homeland health services commenced in the 1970s. Therefore the need for trained black nursing specialists increased even more, because the homelands nursing educational system was not considered as being part of the South African nursing educational system. The first black sister tutor appointed in charge of a college of nursing was appointed in Lebowa in 1978. A black nurse was also appointed as a lecturer at the University of the North. Yet the number of black nursing managers and tutors remained low: the 1978 SANA report indicates that there were 3 172 black nurses with post-basic qualifications. In an effort to assist, South African and the homeland nurses came to an agreement that if there were no training facilities available in the homeland, South Africa would provide it. This was applicable to both basic and post-basic training. In order to assist with the teaching of post-basic training qualifications, in 1976 the University of South Africa (UNISA), with Professor Charlotte Searle in the University Chair, commenced courses in community health nursing, nursing education, and nursing administration. More than half of the students who enrolled for these courses were black nurses (Mashaba 1995:62; Samson 1978:54–55; SAVV 1978:20–24; Searle 1972:280).

4.8.3 Striking as a method of protest

The 1930–1940s saw the rise of workers' unions as black workers in South Africa developed an awareness of social class. In 1930, there were no unions; by 1945 there were 120 unions with 160 000 members (Adhikari 2006:25).

The 1940s also witnessed the first strikes in nursing due to the lack of cross-cultural understanding between white nursing supervisors and black nurses. The nursing strike, for example the Sulenkama strike of June 1949, was a quest for professional and socio-political identity. It had a class and ethnic component to it. Black nurses

wished to perform not only manual labour, but also to be acknowledged for their academic knowledge. What contributed to the Sulenkama conflict was the language barrier: black nurses did not understand English idioms and this contributed to the unrest. It is interesting to note that the Sulenkama nurses strike took place in June 1949; shortly after their close neighbours at Lovedale nursing college had had a strike in May 1949. SANC's reaction to the strike action was to condemn it. Although the organisation acknowledged the validity of the black nurses' grievances, it condemned their choice to strike as it was regarded as unprofessional behaviour (Marks 1994:72–75; Mortimer & McGann 2005:109, 113–117, 119–120).

Some white nurses also participated in strike action during the 1940s although for a different reason. While black nurses protested against inequality in the work place and against racial discrimination in society, white nurses protested precisely to protect the racial hierarchy which was in place in society. It was to prevent the Afrikaner nationalists from using nursing issues as a political platform and to prevent Afrikaner nurses from forming their own union that the implementation of the Nursing Act (45 of 1944) was fast-tracked. The 1944 Act created the controlling body (SANC) and provided a union (SANA) which were acceptable to nurse leaders (Marks 1994:131; Mortimer & McGann 2005:119–120).

Strikes by nurses in South Africa were declared illegal in 1978 (Mortimer & McGann 2005:118).

4.9 NURSING TRAINING 1940s–1970s

In her doctoral thesis, Mashaba (1985:649) states that the training of black nurses was "... satisfactory, but with room for improvement". The room for improvement was evident if one considers the problems faced by black nursing students in the 1940–1950s. They faced overcrowded hospitals with patients sleeping on the floor, no study rooms or anatomical models available and insufficient reference books. The Baragwanath class of 1951 did 54 hours of practical work per week. This explains why school-going black girls cited the conditions in the hospitals as one of the reasons why they did not consider nursing as a career (note discussion on National War Memorial Health Foundation in sub-section 4.6.2 of this chapter). To improve the perception of potential nursing candidates, the National War Memorial Health Foundation

recommended in 1949 that facilities for the training of black nursing students should be improved, a publicity campaign should be launched, and the number of secondary schools for black girls should be increased. However, until the 1950–1960s, student losses continued to be high, with as many as 48% of students failing to complete their nursing courses. The main reason cited was difficulty adjusting to the hospital environment; adjustments to work conditions, and poor salaries. Yet, the number of black nurses steadily increased, and by 1977, South Africa had 17 600 trained black nurses, 5 890 students in training, and 600 black nurses pursuing post-registration nursing degrees (Mashaba 1995:35–36, 52–53, 80; Searle 1972:260).

4.9.1 Training facilities for black nurses: 1940s–1970s

The number of training schools for black nurses gradually increased from two in 1924 to 17 in 1940; 35 in 1964, and 71 in 1977. Of the 35 black nursing training schools mentioned for the year 1964, 46% were mission schools. Despite the evident growth in training facilities, there were still more training facilities for white nurses than for black nurses with no national plan regarding the development of nursing training facilities. The regional distribution of training hospitals for black nurses was also disproportionate to the population densities in the provinces. For example, compared with Natal, the Transvaal (modern day Gauteng, Mpumalanga, Limpopo and North West) had a greater population density but fewer training facilities. Thus the system was provincially driven. This all changed in 1970 with the establishment of a comprehensive health service. The government took over the mission hospitals and so established a single control system for the mission health services (Mashaba 1995:55, 63, 67; Samson 1978:47–48; Searle 1972:305–307, 309).

4.9.2 Educational qualifications needed to enter nursing

Owing to educational challenges in the black secondary school system, nursing candidates in possession of a Standard VIII (Grade 10) qualification were accepted in the 1950s (in 1952 only 5.37% of students had passed Standard X/Grade 12; in 1965 the number stood at 8,6%). In an effort to equip these candidates for the nursing world awaiting them, Baragwanath College (and others) entered the candidates in a six-month preparatory course. The aim was to allow the candidates to adapt to the social environment, learn the English language in which they would be trained, and practise

their mathematics. The most successful of these courses was the cadet nursing programme. By implementing this programme, Baragwanath Nursing College increased their number of nurses who passed the final examination and the students' examination grades were also higher. In 1963 the SANC requirement for entry into nursing was raised to Standard X (Grade 12). Students with a Standard VIII (Grade 10) qualification could still enter nursing by completing the pre-admission course. However, the pre-course was considered discriminatory and was therefore discontinued by SANC in the 1960s. Mashaba (1995:51) states that this decision to cancel the preliminary nursing course was to the detriment of the student who did not have a Senior (matriculation) certificate (Beal 1970:549–550; Mashaba 1995:40–42, 50–51; Searle 1972:294; South African Information Service 1961:6).

4.9.3 University training for black nurses in South Africa

As recently as the 1980s the majority (80%) of university students in South Africa were white. When the Nationalist government came to power in 1948, it compelled racially open universities to accept the policies of apartheid. Only the University of Cape Town and the University of the Witwatersrand were allowed to admit black students using a quota system. Out of a total number of 5 000–6 000 students, 300–400 black students were admitted. The University of Natal had a separate campus for black students and was therefore allowed to continue. To accommodate more black students, the Extension of University Education Bill (45 of 1959) provided for the establishment of four ethnic university colleges: one each for coloured, Indian, Zulu and Sotho–Tswana students. The Bill was met with widespread protest, but supporters of the Bill stated black students' inadequate secondary-school training as motivation for the decision (Baloyi 2004:88–90; Beck 2000:132; Scher 1993:361–364).

A post-basic university diploma in Nursing Education was available to black nurses at the University of Cape Town since 1936 and at the University of Natal since 1956. However, by 1960 no black registered nurse had completed the course and registered at SANC as a sister tutor due to their lack of adequate high-school training. To enter university, students needed a matriculation exemption certificate or a Senior Certificate (Standard X). As discussed in sub-section 4.9.2 of this chapter, few black students had these qualifications. Indeed, most entered nursing with a Standard VIII (Grade 10) qualification (Samson 1978:53–54).

Until as recently as 1970, there was no Baccalaureate university degree course for black nursing students. A number of post-basic diplomas, such as operating room technique, orthopaedic nursing and midwifery, were presented at Baragwanath Nursing College. Also, honours, masters and doctoral courses had only been available since 1967. Then, gradually, university degrees were offered to black students. In 1971, the first black Department of Nursing was established at the University of the North. The university offered the Diploma in Nursing Administration and Nursing Education and later the Baccalaureus Curationis (Instructionis et Administrare) (B Cur I et A) degree. The basic nursing degree only started in traditionally black universities, such as the Medical University of South Africa (MEDUNSA), the University of Zululand and the University of Fort Hare, in the 1980s. The researcher believes that the type and time (1970s) of the courses that were presented coincided with the apartheid government's drive to establish independent homelands. The need to have qualified nursing tutors and managers in the homelands was discussed earlier in this chapter. Again, the government's policy of separate development stimulated the development of black professional nursing in South Africa, but progress was slow: between 1971 and 1977, the University of the North awarded only 15 degrees, 65 diplomas in Nursing Administration and 81 diplomas in Nursing Education. The establishment of a Nursing Department at the UNISA greatly increased the number of black nurses obtaining nursing degrees. By March 1978, large numbers of black nurses were registered for the nursing degree and post-basic nursing degrees at this university (Beal 1970:550; Mashaba 1995:64, 121; Samson 1978:47, 53–54).

4.10 CONCLUSION

The new urgency to train black nurses was created by two important factors. Firstly, WW II created a shortage of nurses at a time when black urbanisation and the subsequent need for access to Western medication occurred at an increased rate. Secondly, there was political motivation in the form of the policy of separate development after the war.

Unfortunately the same policy of separate development which stimulated the growth of the black nursing profession also hampered the entry of black women into the profession. The apartheid educational system led to poorly educated nursing

candidates, and legislation creating segregated societies lessened access to nursing training opportunities. At the same time, the raised SANC entry requirements made the pool of suitable nursing candidates extremely small.

Yet despite these barriers, the number of black nurses in South Africa continued to grow. In the following chapter, their professional development in the *a priori* period 1970s to 1994 will be discussed.

CHAPTER 5

SOUTH AFRICAN NURSING 1970s–1994: STRIVING TOWARDS DEMOCRACY AND UNITY

“Bearing in mind that economic, social and political circumstances are intertwined, it is obvious that these three factors will have a profound influence not only on the community being served but the health professional responsible for this task”
(Hotz 1988:269).

5.1 INTRODUCTION

Chapter 5 of this dissertation describes the sociopolitical, economic, cultural and educational factors which influenced the entry of black persons into professional, Western-styled nursing during the *a priori* period 1970s–1994. The chapter also discusses the development of black professional nurses during the period mentioned – that is, from the time (the 1970s) that the apartheid policies were gradually being relaxed until South Africa’s first democratic elections in 1994.

Schematically, this can be represented as follows.

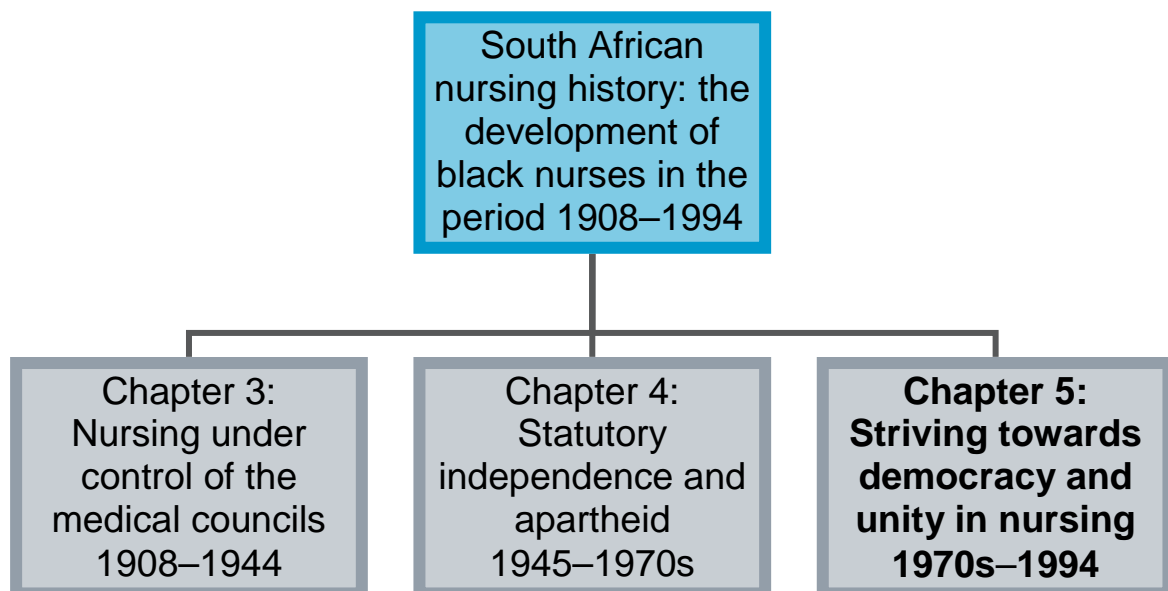


Figure 5.1 Schematic representation of the *a priori* periods discussed in this dissertation

(The period discussed in this chapter is represented in bold.)

5.2 HISTORICAL RESEARCH CONSIDERATIONS EVIDENT IN THIS CHAPTER

In an effort to identify the economic, social, political and cultural factors which influenced the development of black South African nurses, literature sources which provided the most valuable and context-specific information were used. This included general South African history books, history books and articles specific to nursing and South African Acts. Where possible, primary sources were accessed to confirm or refute the description of events provided by secondary sources. This contributes to the trustworthiness of the chapter (Nieuwenhuis 2010:74).

In this chapter quotes from South African Acts are occasionally used to confirm statements or views raised in secondary sources. At times, this posed an ethical problem as some Acts use words, which in modern society are considered derogatory, to refer to African people. Legislation only removed the word “Bantu” from official terminology in 1978. For the sake of clarity and accuracy in quoting, the researcher kept the word “Bantu” where it was used in a primary source, quotes or in legislation. For all other explanations and discussions, the researcher continued to use the descriptive words “African” or “black”.

A few of the secondary sources used in this chapter e.g. the 1978 training report issued by the SANA, have been issued in the Afrikaans language. Other SANA documents were available in English. To distinguish between the documents written in Afrikaans and those written in English, two different references to the author(s) were used. Documents written in English and published by the South African Nursing Association are referenced by using the abbreviation SANA. The Afrikaans equivalent, Suid Afrikaanse Verpleegstersvereniging (SAVV), is used when referencing data obtained from secondary sources written in Afrikaans. Figure 5.2 provides a brief outlay of the topics discussed in this chapter. It should be read clock wise.

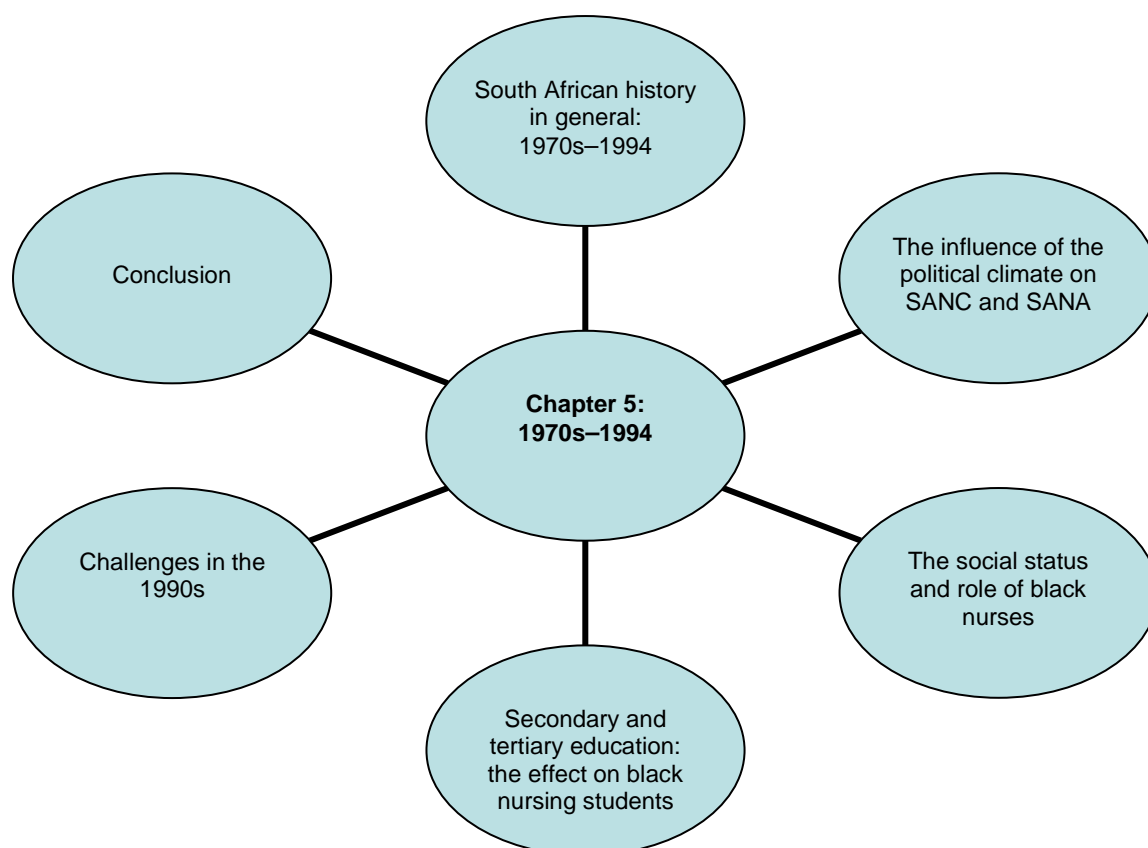


Figure 5.2 Schematic representation of the topics discussed in the *a priori* period 1970s–1994

5.3 SOUTH AFRICA FROM THE 1970s TO 1994: A HISTORICAL PERSPECTIVE

In a conference paper presented at the University of Cape Town, Hotz (1988:269) explained that health professionals (such as nurses) and the communities they serve are influenced by economic, social and political conditions. As in the previous chapters of this dissertation, the researcher will present a short summary of South Africa's general history during the *a priori* period 1970–1994. The rest of the chapter will then explore the influence this general history had on the growth and development of black nurses in the country.

5.3.1 Issues of black labour and economy: 1970s–1980s

The historical uprising against the socio-economic and political conditions in which black South Africans found themselves started in Soweto on 16 June 1976 and soon spread to other areas in South Africa. The NP government could not turn a blind eye to the

social upheaval and in 1977 appointed two commissions to investigate the effect that apartheid laws were having on black labour. The Wiehahn commission focused on how apartheid legislation influenced the Department of Labour and Mines, while the Riekert commission investigated areas other than the Department of Labour and Mines (Liebenberg 1993:461–463, 469; Makgoba 2006:25–27).

In 1979, the Wiehahn commission's report recommended that government should recognise black trade unions (which implied that they would be allowed to strike), stop the practice of reserving certain jobs for white people, and implement the principle of "equal wages for equal work", regardless of race. In The Labour Relations Amendment Act (57 of 1981) all reference to race was removed. The Act also allowed for the registration of multiracial trade unions. Therefore, most of the commission's recommendations were accepted and implemented. All reference to race was removed from SANA's constitution in 1989 (Liebenberg 1993:469–470; Makgoba 2006:25–27; Marks 1994:206).

The Riekert report, also released in 1979, stated the importance of retaining the principle of influx control in South Africa. It confirmed the government of the day's belief that the movement of people from the so-called homelands into the cities must be controlled in order to prevent social and security problems. The result for urban black people was that they had more economic freedom (due to the recommendations of the Wiehahn commission), but no sociopolitical freedom. In time, it became evident that the system of influx control did more harm than good; therefore, it was abolished in 1986 by means of The Abolition of Influx Control Act (68 of 1986) (Liebenberg 1993:471; Makgoba 2006:25–27).

5.3.2 The South African political climate: 1970s–1990s

After the resignation of John Vorster as South African prime minister, PW Botha took over the reigns of the apartheid government in September 1978. He firmly believed that white people must remain in control of the country, yet was willing to consider changes in the application of apartheid policy. Thus he founded the multiracial President's Council in February 1981, but without the inclusion of black persons. To a limited extent, Botha promoted reform in apartheid policy. A faction within the NP rejected the idea of sharing white power with Indian and Coloured people and therefore caused a split in the

ruling party. Andries Treurnicht formed the Conservative Party in March 1982 and FW de Klerk, future prime minister of South Africa, took over as leader of the NP in the (then) Transvaal (Liebenberg 1993:464, 473, 475–476).

The multiracial President's Council was the result of political processes which had started as early as August 1976, when the government decided to investigate a possible new system or systems of government. This process culminated in the South African Constitution of 1983. The new constitution mainly differed from the 1961 constitution in that it allowed the continued existence of the President's Council and the implementation of a three-chamber parliament for white, coloured and Indian people. The new constitution was approved by the white voters in South Africa with a 65,9% "Yes" vote in a referendum held on 2 November 1983. Although black people were excluded from these changes, it was an important political move for the country because the apartheid government was relaxing its "whites only" principle. The first mention of power sharing between blacks and whites was made by PW Botha in his speech to the House of Assembly in January 1985 (Liebenberg 1993:472, 477–478, 494).

The 1980s were marked by increased international political and economic pressure on South Africa to abandon the system of apartheid. This pressure reached its peak after PW Botha's 1985 Rubicon speech in parliament. International countries greatly increased their economic sanctions against South Africa in consequence of which the South African economy slowed down significantly and precipitated an economic recession. The poorest in the country suffered the most (Liebenberg 1993:510, 526; Makgoba 2006:25–27; Maloka 2006:54–55).

In 1984, black people in the Vaal Triangle started to revolt against their living conditions, and during the next two years the revolt gradually spread throughout the country. Under the influence of the ANC, black people protested about the economic recession and the 1983 Constitution which excluded them from political power-sharing. In reaction, the apartheid government, led by PW Botha, created the State Security Council to suppress the uprisings. A state of emergency was declared twice: from 21 July 1985 to 7 March 1986 and again from 12 June 1986 to 11 June 1990 (the longest state of emergency in South African history). During these states of emergency, police and soldiers were given extensive power to control entry into residential areas. They

were also allowed to detain people for more than 14 days if deemed necessary in the interests of state security. Therefore, apartheid rule in the 1980s was conducted on strong militaristic lines: anti-apartheid organisations were banned, meetings were declared unlawful, and the freedom of the media to report on these matters was restricted (Field 2006:45–50; Liebenberg 1993:468, 498–499, 500–505, 528; Nieftagodien 2006:52–53).

International economic and political organisations pressured the apartheid government into considering political change. Therefore, from 1984 to 1991 a gradual move away from apartheid could be observed: more than a hundred pieces of legislation enforcing apartheid were abolished or amended. One such Act was The University Amendment Act (83 of 1983), which allowed people of all races to attend traditionally “white only” universities. The Abolition of Influx Control Act (68 of 1986) cancelled the pass laws to which black people had previously been subjected. Black people could now remain in urban areas for more than 72 hours without permission and could also buy and own land in such areas. In June 1991, The Group Areas Act (36 of 1966) was repealed, which meant that people of all races could now choose where they wished to live. Finally, The Population Registration Repeal Act (114 of 1991) declared that no racial reference would be noted on the population register for all babies born in South Africa after 27 June 1991 (Liebenberg 1993:488, 493).

Marks (1994:189–192) states that the apartheid government’s efforts to segregate hospitals racially never fully succeeded as the shortage of white nursing staff made it impossible. For example, in 1973 the director of the Transvaal hospital services threatened to close down any private hospital which employed black nurses to care for white patients. However, by 1976 the shortage of white nursing staff forced the Minister of Health to authorise the use of black nurses to care for white patients. The black nurses received the same remuneration as their white counterparts for services rendered. The policy of racial segregation in public hospitals formally ended in 1991 (Marks 1994:206).

The year 1990 heralded great changes in South Africa’s political landscape: President FW de Klerk, who took over the reins from PW Botha, unbanned the ANC in his parliamentary opening speech on 2 February 1990 and ordered the release of Nelson Mandela and seven other political prisoners. The longest state of emergency in the

history of South Africa ended in June 1990. In September 1991, most political entities, including the government and the ANC, signed the National Peace Accord. The gradual move away from apartheid politics culminated in South Africa's first democratic election in which all races, black people included, could participate on 27 April 1994 (Du Preez 2006:37; Field 2006:45–50; Liebenberg 1993:516, 524–525, 531).

5.4 THE INFLUENCE OF THE POLITICAL CLIMATE ON SANA AND SANC

The momentous sociopolitical changes mentioned in section 5.3 had a significant impact on how nursing practice was conducted and changed during this period.

5.4.1 The influence of the ICN on the promulgation of the Nursing Act (50 of 1978)

As discussed in chapter 4, sub-sections 4.7.2 and 4.7.3, South African nurses practising in the 1960s to 1970s were guided in their practice by the racially specific Nursing Act (69 of 1957). The existence of this Act produced one of the most remarkable events in South African nursing history.

SANA had joined the ICN as a member in 1922. One of the ICN's specific objectives was to serve as the "... authoritative voice for nurses and nursing internationally" (Du Preez & Brannigan 1991:35). Membership of this organisation thus provided SANA with an international platform on which to promote all matters related to professional nursing.

In May 1973, the ICN held a congress in Mexico City which Charlotte Searle, the president of SANA, attended. The sources consulted by the researcher appear to be similar in their explanation of the events prior to the congress, but the reasons cited for SANA's withdrawal of its membership from the ICN are more controversial.

The 1891–1991 SANA Centenary Publication (Du Preez & Brannigan 1991:35–36), a book celebrating the first one hundred years of South African nursing, explains that there were indications before the 1973 Mexico Congress that the ICN would exert pressure on SANA to dissociate itself from the racially specific Nursing Act (69 of 1957). The publication states that the ICN's objections to the Act were, however, not the principal reason for SANA's membership withdrawal; rather, it was due to the ICN's

support of strike action by nurses, and policy changes regarding membership which had financial consequences for SANA. ICN membership was no longer restricted to registered nurses but extended to include all categories of nurses. As the ICN membership fee was based on a *per capita* structure, it would have been very expensive for SANA to continue its membership. Therefore the SANA Board decided in a meeting held after the international congress to withdraw from the ICN, citing reasons of finance and principle related to strike action by nurses. This interpretation is, however, contested by Marks (1994:184–187) who refers to ICN records in support of her belief that SANA was forced to withdraw from the ICN due to the existence of the racially motivated Nursing Act (69 of 1957).

Irrespective of the reasons why SANA withdrew from the ICN; the decision to do so had a marked effect on the South African nursing profession. In future, SANA would have only limited access to information related to international nursing trends and, more importantly, the status of the South African profession was no longer internationally respected. This situation prompted the country's nurse leaders to negotiate changes to the Nursing Act (69 of 1957) with the South African Minister of Health, and to suggest that the "whites only" principle should be removed from the legislation. The end result of these negotiations was the Nursing Act (50 of 1978). Marks (1994:186) views the Act as an attempt to "satisfy world opinion" and to discourage nurses who were becoming involved in unions from participating in strike action (Marks 1994:184–187; Mashaba 1995:66).

5.4.2 The changing roles of SANC and SANA as defined by the Nursing Act (50 of 1978)

In its original form, the Nursing Act (50 of 1978) was more liberal in spirit than the Nursing Act (69 of 1957). It allowed for the election of a multiracial SANC Board: 5 white, 3 black, 1 Coloured and 1 Indian registered nurses. However, only registered nurses (no sub-categories) could vote and only South African registered nurses could participate. Nurses who lived and worked in the so-called homelands could not vote in the election of the SANC Board as they had their own nursing boards, which had been established in accordance with the government's Bantustan policy. The three black nurses voted onto the SANC Board were elected by the black nurses of South Africa only, while the five white nurses, elected by the white nurses and forming the majority

on the Board, ensured the likelihood that the President of SANC would be white. Marks (1994:193) argue that Searle succeeded in "... opening new avenues for black nurses without threatening white control ..." (Marks 1994:187–189, 193; South Africa 1978:9, 11, 13, 16). It can thus be argued that Nursing Act (50 of 1978) had conciliatory overtones and was giving something to black nurses, while at the same time withholding influence from them and preserving the hegemony of white nurses.

The Act contains racial overtones as it provides definitions of white and "Bantu" persons. "Bantu" persons were defined in terms of the Population Registration Act (30 of 1950). The first amendment to Nursing Act (50 of 1978) was made in 1981 and it was the first of many: from 1981 to 1997 the Act was amended no fewer than twelve (12) times (South Africa 1978:9, 11, 13, 16). These amendments illustrate the gradual relaxation of apartheid principles.

The years 1985–1989 also witnessed changes in SANA's constitution in that all reference to race and the racial ratios required on the SANA Board were removed. The association also accepted the concept of collective bargaining (Du Preez & Brannigan 1991:39). The process of collective bargaining allows trade unions to negotiate working conditions with employers, a concept previously unknown to the nursing profession.

Searle (1988:80) explains the role of SANC and SANA as described in Nursing Act (50 of 1978) and states that it is a misconception that SANC protects the public and SANA protects the nurse. Rather, "... each function of protection of the public also directly or indirectly confers a certain status on the nursing profession and the development of the profession is in the interest of the public". She further explains that the South African nursing profession holds the unique position of not only serving the public, but also being "in a special consultative capacity" to the Minister of Health in matters concerning health services and the nursing profession in this country (Searle 1988:80). This consultative role is reflected in the nursing profession's discussions with the government of the day in an effort to amend the racially biased Nursing Act (69 of 1957).

Searle (1988:80) furthermore confirms that membership of SANA was compulsory for all practising nurses in South Africa during the 1970s–1980s. The association showed a remarkable growth in numbers over the years, and it is this researcher's deduction that this growth can, to a certain extent, be explained by the compulsory membership.

SANA commenced in 1944 with 3 600 members at 27 branches, which by 1978 had grown to 90 578 members at 118 branches. It is significant that there were an estimated 149 175 members; of whom 132 280 were paid-up members, at 103 branches in 1990. The researcher deduces from this that compulsory membership did not necessarily translate into active participation in the association. Unfortunately, the SANA report does not indicate which categories of nurses were less or more active, but only provides total numbers (Du Preez & Brannigan 1991:40; Ehlers 2000:77; Searle 1988:80–81).

SANA had three important objectives, namely to advocate the educational needs of nurses, to develop competent nurses, and to develop nurses who could participate in the control and management of their profession. “The Association is the profession and the profession is the Association, and from its ranks the persons who will control the standards of the profession during their term of office must be drawn” (Searle 1988:80–81). The purpose of the association is also analysed and described in the centenary publication, *State of the Art of Nursing*. A short phrase, “Nursing history is well documented ...” (Du Preez & Brannigan 1991:43) caught the researcher’s attention and caused her to realise that this 1991 statement was relevant to European nursing history only. The reason is that African nursing and the unique contributions of African nursing pioneers are not yet well documented. Future South African nursing historians still have a daunting task ahead of them.

Compulsory membership of SANA ended in 1993 with the amendment of Nursing Act (45 of 1944). This amendment made it possible for nurses to join trade unions and participate in strike action for the first time since the formation of the SANC and SANA in 1944 (Ehlers 2000:77–78).

By 1994, the changes to the SANC Board and the SANA constitution had the desired effect. Black nurses were gaining professional freedom (albeit gradually) and the South African nursing profession moved from being politically, socially and economically isolated to being members of international organisations such as the World Health Organization (WHO) and the ICN (Ehlers 2000:76).

5.5 THE SOCIAL STATUS AND ROLE OF BLACK NURSES: 1970s–1990s

As discussed in chapter 4, black nurses occupied a unique position within South African society. They were westernised in their education and work, yet they were also very much part of the African community and tradition they were born and raised in. It is therefore important to investigate black nurses' social role in the second half of the twentieth century.

5.5.1 The social status of black nurses in comparison with the social status of the black population in the 1970s and 1980s

The urbanisation of the South African population commenced at the beginning of the twentieth century, continued during the 1970s and is still proceeding at the start of the twenty-first century. In 1904, 10% of black (compared with 53% of white) South Africans lived in cities. By 1980, urbanisation had escalated to 33% of the black (and 88% of the white) population, and in the year 2000, 47% of the black population were urbanised (in comparison to 90% of the white population). The increased rate of urbanisation and the growth in the African population had an influence on health-care delivery (and therefore nursing) in South Africa. Although a more favourable infant mortality rate (less than 100 per 1000 live births by the 1980s) was observed, the health of black people in general was declining in the 1980s, placing a greater burden on the South African health-care system (Hunt 1991:2–4; Liebenberg 1996:480–482; Rispel & Schneider 1989:22).

The greater burden on the health care system was in part due to the housing conditions which prevailed. Despite the rapid urbanisation of black people, the apartheid government did not spend large amounts of money on providing adequate housing in the townships. The scarcity of suitable housing created a situation which made it very expensive to buy or rent. Poor people could not afford it and therefore had to make alternative housing arrangements. For example, the population of Katlehong increased from 95 000 in 1970 to 200 000 in 1980. Despite this large increase in numbers, only 100 houses were built in the area during the period 1973–1979. Therefore people resorted to building makeshift, informal dwellings. This type of home increased within two years from 8 000 to a total of 24 000 in Katlehong alone. Similar conditions were evident in Soweto where 23 000 informal houses were counted in 1982. Poor housing

negatively influenced the health of the residents, which placed a greater burden on the health care system and therefore nurses. From these examples, the researcher deduces that the situation was similar in other black townships in South Africa. African people did not accept these conditions and established civic organisations which protested against the expensive rent system and the government's destruction of informal houses. In these protest actions, black women played an important role (Nieftadogien 2006:59–61).

The social conditions described in the previous two paragraphs had an influence on black professional nurses: they lived in the townships and therefore had the options of either paying for expensive housing or living in an informal house. Thus the nurses themselves were vulnerable to ill health due to poor housing. In addition, the ill health of the community made the nurses, who nursed them, more vulnerable to diseases such as tuberculosis. The location of townships away from the inner cities meant that nurses had long distances to travel between their homes and their places of work. Despite these circumstances, black nurses formed part of the newly developed black middle class. They were considered social elite (Marks 1991:2, 6; Rispel & Schneider 1989:9).

The black nurses' tertiary education separated them from the working class. In fact, many black nurses distanced themselves from the working-class man. This social divide assisted the government in creating a new black middle class. This in part explains why black nurses remained in the profession despite the difficult working conditions and low salary. Black nurses were caught in the middle: on the one hand, they were placed in socially superior positions in their communities; on the other hand, the community expected them to participate in the protests against the very government which had enhanced their social standing (Marks 1991:5; Rispel & Schneider 1989:9, 18, 22–23).

5.5.2 The social status of black nurses in the 1990s

Some things change; others remain the same. This statement is relevant to the social status of black South African nurses in the 1990s. Teaching and nursing, as in previous decades, remained the two important professions available to black women (Van der Merwe 1999:1273).

Even in the last decade of the twentieth century, black professional nurses were still caught between their traditional African way of life and the values of the Western-styled nursing profession. However, a slight shift in focus occurred. In interviews with black nurses, Van der Merwe (1999:1272) discovered that rural black nurses in particular felt more oppressed by their culture than by their race. By using their education and personal qualities, black nurses had learned to empower themselves by creating their own type of freedom. Yet, in their roles as black women, they had less power and more domestic responsibilities than their male counterparts. In this regard, many had little or no support from their husbands (Van der Merwe 1999:1276–1277).

In chapter 4, sub-section 4.5.4 of this dissertation, the entrance of married women into the nursing profession was discussed. The Second World War had necessitated an increase in nursing numbers and therefore married women were allowed to enter the profession in greater numbers. By the 1970s, married women comprised 66% of the nursing corps and, in 1990, 51,8% of working nurses reported having children (SANA 1980:57–58; SAVV 1990:25; Searle 1975:57; South African Information Service 1961:10). In the light of the discussion in this and the previous paragraph, it must be acknowledged that the responsibilities of home, children and work, with little support from their husbands, must have placed a heavy burden on the shoulders of black nurses.

Throughout this dissertation, the point is made that black nurses were regarded as a social and educated elite within the black communities of South Africa. One may ask if this still holds true at the end of the twentieth century and, if so, what yardstick black nurses used to measure this perceived status. Horwitz (2007:135) interviewed black nurses who trained at Baragwanath hospital in the 1940s. From these interviews it was evident that, even during the apartheid era, black nurses based their perception of a professional image on that of Florence Nightingale and Henrietta Stockdale. Years later (when interviewed in 2004), they were of the same opinion: one of the most important status symbols was the white nursing uniform worn by nurses which was associated with increased status and commanded respect from others. The nurses stated that the patient had to see “some glowing person” taking care of them. And finally: the white uniform challenged the stereotypical view that all black people are “dirty”. The emotional connection with the nurses’ white uniform is still ongoing, as illustrated by

discussions held at the 2011 Nursing Summit, where it was proposed that nurses should retain the white uniform worn in previous decades (FPNL 2011; Horwitz 2007:133–135; Kitshoff 2011).

5.6 THE EFFECT OF SECONDARY AND TERTIARY EDUCATION ON BLACK NURSING STUDENTS 1970s–1994

Although the South African secondary school system and its influence on the recruitment of black nurses have been discussed in chapters 3 and 4, the educational factor remained one of the major barriers to entry into nursing during the last three decades of the twentieth century, especially if the changes in nursing education that occurred in the 1980s are considered.

5.6.1 The influence of politics, culture and the secondary education system

In the 1970s and early 1980s, black secondary education was functioning poorly: there were a shortage of well-equipped classrooms and trained science and mathematics teachers. The teacher-pupil ratio ranged from 1:48 in 1978 to 1:39 in 1982 (the ideal being 1:20). These ratios are alarming if one considers that, until 1979, schooling for black children was not compulsory and that only 20,9% of black children attended school in 1982. Of those who did attend school, many left school before completing Standards 9 and 10 (Grades 11 and 12). Despite efforts to improve the situation, these conditions prevailed into the early 1990s (Luthuli, Masiea & Zuma 1992:32–33; Mashaba 1986a:2; Mashaba 1986b:396–398; Olivier 1984:47–54).

In the 1980s, the De Lange Commission recommended that changes should be made in black education. In consequence of these changes, the number of South African black children attending school greatly increased between 1978 and 1990. Yet, the matriculation pass rate in 1990 remained less than 90% because the country was experiencing far-reaching political changes. Prior to 1994, black parents and adults viewed education as second in importance to political freedom. School boycotts hampered secondary education as the following examples illustrate. There were 25 school boycotts in 1983, with 220 000 students absent from school. In 1985, half a million students in 907 schools were affected by school boycotts, with 294 schools being damaged in the process. As a result, young black learners did not develop a

culture of learning and black teachers considered “mass action ... a way of life ...”. By 1986, concerned organisations such as the Soweto Parents’ Crisis Committee and the National Education Crisis Committee (NECC) made efforts to get children back to school (Baloyi 2004:135–151; Liebenberg 1993:505–506).

Black children had to learn in a Western-styled environment with limited support from parents and teachers. Although black culture had changed due to urbanisation, certain cultural practices related to education still prevailed. Traditionally, intellectual stimulation of the child occurred by means of stories and puzzles told verbally. The education of the child occurred primarily through the family and the community. By contrast, in a Western-styled educational system, intellectual stimulation occurs by means of the written word. The problem was that, books and libraries were not readily available in black homes and schools. This stunted the intellectual preparation of the child for secondary and tertiary education. Semi-literate or illiterate parents could not teach their children the principles of Western problem-solving techniques or how to analyse their world. Consequently, they could not assist their children in learning study material written in a foreign language (Luthuli et al 1992:32; Olivier 1984:42–45). Given these educational and cultural realities, one can understand the daunting challenges that black students faced with regard to the theoretical component of the nursing course, which requires critical analysis and problem-solving skills. In the researcher’s experience as a nurse educator, this is an ongoing problem. During a theoretical contact session held recently, the students informed the researcher that it is not good to ask “why?”; matters should only be accepted.

One cultural practice which prevented black nursing students from excelling in the practical nursing field was the tradition of the elders in a community making all the important decisions. Black women, in their role as professional nurses, were required to make individual decisions related to patient care at a very young age; yet it was against their social upbringing. Therefore, they were often criticised by Western colleagues as being irresponsible. Culturally, black children seldom practised self-criticism, with the result that they accepted criticism from others with difficulty (Luthuli et al 1992:32; Olivier 1984:42–45).

5.6.2 Changes in nursing education: 1970s–1994

As discussed in chapters 3 and 4 of this dissertation, SANC and SANA were established in 1944 with the purpose of developing an effective, formal nursing training system and establishing nursing as a recognised profession. Therefore the publication of the De Lange Commission report in the 1980s had a profound effect on nursing education. The commission defined formal education as education being presented at “recognised educational institutions such as schools, colleges, technikons and universities” (Mashaba 1995:128). This definition prompted nursing education to move away from the hospital as a place of learning – a process which started in 1982 and was completed in 1986 with the implementation of the four-year integrated nursing course (Mashaba 1995:128–129).

It was envisioned that the educational changes would be completed by 1986, with the new four-year integrated nursing course being the only course available and being presented at tertiary education institutions. This drive to establish nursing training as a formal system implied that hospital training schools were no longer recognised. Nursing colleges, which traditionally were part of the hospitals, were required to create partnerships with universities, and the students would write a college examination instead of the SANC examination (R 2118 of 1983). Therefore, the hospitals became the place for clinical learning only (Manzini 1998:24–25; Marks 1991:3; Mashaba 1986b:395–396; SANA 1984:2–4).

Although these changes formalised nursing education in South Africa, they also presented an obstacle to black nursing candidates. With the promulgation of Nursing Act (50 of 1978), all racial groups in South Africa received the same training. The shift to tertiary nursing education favoured nursing candidates who had a matriculation (Grade 12) qualification, a solid educational background and independent learning skills. Unfortunately, the different secondary educational backgrounds from which the nursing candidates came were not taken into consideration. Black nursing candidates’ weak educational background prompted Mashaba (1986b:401) to state: “... remedial action needs to be taken urgently in the area of secondary school education. Alternatively a bridging course could be designed.” This educational weakness of black candidates in relation to the new nursing entry requirements created a conundrum for nurse leaders: in order to reach the millennium target number of trained black nurses

(as calculated by Searle), the nurse leaders had to be lenient with regard to the entry requirements and admit candidates without the requisite scientific background to the course. These nurses performed well in the practical component, but poorly in the theoretical component of the course. They were also weak with regard to theory-practice correlation (Mashaba 1986a:1, 3; Mashaba 1986b:396, 398–399). In the researcher's experience as a nurse educator, the above-mentioned problems remain a major problem to this day. Students who enter the current two-year Enrolled Nurse (R2175) and Bridging to Registered Nurse (R683) courses by means of recognition of prior learning (RPL) do not always comply with the entry requirements regarding science subjects. These learners generally need support in order to understand the theory and apply their knowledge. Generally, they also obtain low-to-average marks in theoretical tests, but excel in practice.

From 1944, under the leadership of SANC, nursing education developed into a formal, tertiary education system; yet, by the 1990s, many challenges still remained. A large number of black nursing candidates never completed their training and were lost to the profession. Therefore the recruitment of suitable candidates and their retention remained a barrier to increasing the number of trained black nurses. The time spent in class (37%) versus the time spent in clinical practice (64%) remained a discussion point – especially in the light of the nurse educator shortage which existed at the time. The inability of the few nurse educators to provide effective clinical accompaniment also contributed to nursing candidates leaving the profession. In addition, the shortage of qualified nurse educators impeded the academic growth of those who remained on the course. The Western-styled curriculum itself, with its use of medical terminology, did not prepare nurses to care effectively for the needs of the rural communities in South Africa. University boycotts and riots handicapped those who wished to focus on their studies. In addition, the nurses in South Africa had little contact with nurses from other African countries (Manzini 1998:3–6; Mashaba 1995:137–138; SAVV 1990:20).

5.6.3 The new nursing education structure created barriers for black nursing candidates

Research into the racial distribution of student nurses in training indicates that there were a large number of white students registered for training at South African universities, while the number of black students enrolled for the bridging programme

was higher. This illustrates that black nursing students' weak secondary schooling negatively affected their ability to excel at tertiary academic level. It has been suggested that white nurses were more likely to be employed in the private hospital sector due to their "historical educational privilege" (Breier et al 2009:21).

The first attempt to reform the South African tertiary system so that its students would more accurately represent the demographics of the country was the National Commission on Higher Education (NCHE) document, *Overview of a new policy framework for higher education transformation* published in 1996. Its focus was the increase of student numbers in the age group 18–24 years and improving access to universities for black students (Breier et al 2009:21–22; Luthuli et al 1992:30–32; Mdepa & Tshiwula 2012:19–21).

One of the major educational barriers to the development of black professional nurses was the fact that modern tertiary courses were (and mostly still are) presented in the Western style. The English language poses a major problem to black students who did not master the basic language skills at secondary level. For example, many black students tend to use vague, non-descriptive language in tests and assignments. Even if they are generally proficient in English, they find some scientific concepts difficult to understand as there are no equivalent concepts in the traditional African languages. Some learners also experience difficulty with the mathematical principle of "zero" as it does not have an equivalent in certain African languages (Luthuli et al 1992:30–32; Olivier 1984:56).

From the 1980s to the present, black nursing candidates, who had received a poor scientifically oriented secondary education, were faced with the challenges of completing a scientifically oriented tertiary, university-level nursing qualification in a foreign (English) language. The poor secondary education system ensured that some new candidates were ill-equipped for the challenge as they had obtained poor matriculation results (many obtaining only an "E" aggregate, the lowest grade with which to matriculate). As stated in the previous paragraph, most of the candidates did not master English, the dominant language of tuition at tertiary level. Few took science subjects and many of those passed the science subjects poorly. They were also negatively affected by the lack of competent science teachers. Owing to this lack of a

solid educational foundation, a large number of black nursing students failed the SANC examinations (Mashaba 1986a:1; Mashaba 1986b:396–397).

The envisioned tertiary nursing education system also created problems for the black nurse educators and their ability to support and facilitate the learning of the nursing students. The ideal nurse educator to student ratio is 1:15. However, the black nursing students' weak secondary educational foundation increased the workload of the nurse educator. Not only did the SANC curriculum have to be taught, but the nurse educator also had to deal with the black students' lack of English language and scientific skills (which should have been developed by the time the student reached the last year of schooling). This lack of scientific skill, as well as many black students' inability to study independently, limited the nurse educator's choice of teaching methods. Clinical teaching and patient care were therefore also negatively influenced. This led Mashaba (1986b:399) to state: "If a tutor did a good job of all this she would be more of a magician than a tutor." (also see Mashaba 1986a:3; Mashaba 1986b:396, 399–400; Olivier 1984:56). In her experience as a nurse educator and as discussed in previous paragraphs of this chapter, this researcher is of the opinion that these challenges still face educators and students today.

The challenge facing nurse leaders was how to ensure an appropriate balance between the theoretical knowledge and practical skills that black South African nurses (and other racial groups) are required to have. In order to address this issue, the prevailing secondary education system and its outcomes (40% of black Standard 10/Grade 12 learners matriculated in 1988) had to be considered. From this small pool of matriculants, 5.6% of female matriculants might be recruited into nursing. Curriculum planners needed to find a solution to the problem of the high drop-out rate prevailing in nursing courses versus the need to have sufficient numbers of trained nurses to care for the South African population (Rispel & Schneider 1989:21; SAVV 1990:17).

The drop-out rate from nursing courses (candidates not completing the course) gradually declined from 70% in 1976 to 31% in 1984, but remained unacceptably high. The majority of candidates were lost in the first year of training. There were multiple reasons for this high loss: the foreign language of education, the need for embedded scientific knowledge, criticism from ward staff, the high expectations of nurse educators, the candidates' real interest in nursing (26% of those who drop out were not interested

in nursing) and social issues such as early marriage, distances from nursing education institutions and poor study habits. Manzini (1998:242–245) interviewed 190 nursing students who dropped out and found the following:

- 20,5% of the respondents had passed high-school mathematics
- 12,6 % of the respondents had had physical science as a subject
- Only 20% of them stated that English was their home language
- 91,6% of those who dropped out were female (marriage and pregnancy were cited as reasons) (Manzini 1998:17, 37–38; Mashaba 1986a:3; Mashaba 1986b:400)

It is also significant that a higher drop-out rate was recorded in 1990 and 1992. Manzini (1998:244–245) provides a sociopolitical explanation, stating: “The democratic process was new to most South Africans and it was therefore widely misunderstood to mean freedom without responsibility, which could contribute to the drop out.” Thus a need was identified for student counsellors who could guide students, not only with regard to subject and career choices, but also with regard to life skills in a democratic South Africa (Makhaya 1988:159).

5.7 CHALLENGES FACING BLACK NURSES IN 1994

By 1980, black nurses could be found in nursing leadership positions. They were matrons, nursing college principals, and directors of state nursing services. Therefore the professional development of black nurses appeared to have been successful. A number of educational challenges remained, such as creating academic literature specific to the language needs of South African nurses. Student recruitment and selection had to be revised and adapted and, finally, the shortage of qualified, competent nurse educators had to be addressed. In this regard, it appears that the challenges which faced nurse leaders in the 1990s did not differ much from the challenges which nursing pioneers had had to address. Nurses still had to provide diverse types of care to a diverse, ever-increasing population. The weak secondary education system, as well as a number of sociocultural factors, still created formidable barriers which black nurses had to overcome (Mashaba 1985:651–652; Searle 1988:124–127).

It will be a challenge for future historians to study the growth or decline of black nursing numbers in South Africa, because all references to race were removed from the SANC registers in the late 1980s. Therefore, statistics regarding the number of nurses, based on race, are only available for the period 1960–1990. Breier et al (2009:21) quote a SANC representative as stating that “We live to regret that decision ...”.

The challenge facing black South African nurse leaders in the twenty-first century is best worded by Gumbi (1991:161–162) who states that future generations of nurses will be building the profession on a sound ethical and philosophical foundation. The rules and services are in place; now quality and refinement must be added.

5.8 CONCLUSION

The *a priori* period 1970s–1994 witnessed a gradual move away from apartheid policies towards the implementation of true democracy. The nursing profession not only experienced the influence of politics, but also implemented major changes to the nursing educational system. The changes made in the educational system created an obstacle for black nurses to overcome because their secondary education did not equip them with the necessary skills to excel in the world of tertiary education. Despite these barriers, black nurses in South Africa appear to have developed into nurse leaders capable of leading South African nursing into the twenty-first century.

CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

"I want to take you back a century, and to ask you whether the nurses of this country have not succeeded against almost insurmountable odds to build the profession that we know today"

(Searle 1988:123).

6.1 INTRODUCTION

Few South African nurse educators use historical inquiry in their research and teaching. As a result, the study guides and historical textbooks used in South African nursing lectures are dominated by British nursing history. Yet, the younger generations of nurses do not identify with a historical perspective that presents a mostly Western influence on South African nursing. Although the importance of this Western influence on the early history of professional nursing cannot be denied, there is a need to include South African nursing history in particular in current teaching and writing activities. It is therefore important that the history of black nurses in South Africa should be researched and recorded, as it is a history to which most current South African nursing students can relate. It was this need that provided the impetus for the research recorded in this dissertation.

This qualitative study explored nursing literature by means of historical inquiry in order to identify the economic, social, political and cultural factors that influenced the professional development of black South African nurses in the period 1908–1994.

The research population encompassed all the accessible nursing literature related to the objectives of this dissertation. Sample selection was performed by means of a non-probability sampling approach. As historical inquiry demands that information-rich sources be included in a study of this nature, an unstructured data-collection method was used. However, in order to ensure that historical events were portrayed in an unbiased manner, only historically accurate literature was included in the study.

Historical inquiry does not confine itself to a specified time or occasion for data analysis, but evolves during the gathering of literature, reading and reflection phases of

the process. Yet such a procedure is not necessarily unstructured. The researcher needs guidance to understand historical events and the context in which they occurred. This guidance was provided by means of *a priori* periods: the period 1908–1994 was divided into a number of eras based on the occurrence of significant historical events. The use of *a priori* periods provided context, yet allowed sufficient flexibility to include all the factors identified as having had an influence on the development of black professional nursing in South Africa.

Repeated reading and reflection on the historical data, as well as checking more than one source related to a specific historical event, assisted the researcher in enhancing the trustworthiness of the data. This brought new insights and newly identified factors of influence to light, which was especially evident during the reading and writing of the first two *a priori* periods. The third *a priori* period confirmed the findings of the first two, thus allowing crystallisation to be reached by the end of the last *a priori* period.

The nature of historical inquiry leads a researcher to answer more than only the stated research objectives. One cannot present a historically plausible explanation of events if all the influencing factors and the historical setting in which they occurred are not considered. It was therefore impossible to exclude specific reference to the sociopolitical conditions which prevailed in South Africa during the period 1908–1994. The researcher's conscious and/or unconscious biases in presenting these historical events had to be considered. These considerations led to the use of a strict ethical code imposed on all historical researchers (presented in chapter 2 of this dissertation), using reflection in order to enhance bracketing, and reading about the historical topic of choice until crystallisation had occurred.

6.2 PURPOSE OF THE STUDY

A retrospective analysis of past events provides humankind, and for the purpose of this dissertation, nurses in particular; with knowledge of the past. Such knowledge provides people with a sense of belonging and pride. It gives nurses insight into the current issues that face their society in general and the nursing community in particular. Only if the past is known and understood, can a society (and the nursing profession) generate new ideas and values that will shape its future, because this knowledge helps the

members of that society to understand where they came from (Brink & Wood 1998:356; Burns & Grove 2009:58; Galgano et al 2008:1–2; Lewenson & Hermann 2008:2).

After writing the entry examination on 19 December 1907, the first black African woman, Cecilia Makiwane, registered with the Cape Medical Council as a professional nurse in January 1908. This event heralded the start of professional black nursing in South Africa. By 1990, only one-third of the nurses registered with SANC (approximately 150 000) were white. Two-thirds (excluding apartheid 'homeland' registrations) were coloured and black nurses. This rapid increase in numbers prompted the researcher to reflect on the historical factors which influenced the professional development of black nurses in South Africa.

The specific research objectives reached in this study were the following:

- By means of historical inquiry, explore nursing literature in order to identify the economic, social, political and cultural factors that influenced the development of black South African nurses in the period 1908–1994.
- Document the abovementioned period of nursing history in order to assist nurse educators in teaching students an inclusive South African nursing history.

6.3 CONCLUSIONS

In this dissertation, the researcher divided the historical period 1908–1994 into three *a priori* periods namely:

- 1908–1944: Nursing under control of the medical councils
- 1945–1970s: Statutory independence for nursing and the influence of political apartheid ideology
- 1970s–1994: South Africa's, as well as the South African nursing profession's, striving towards democracy and unity

Figure 6.1 provides a schematic representation of these three periods.

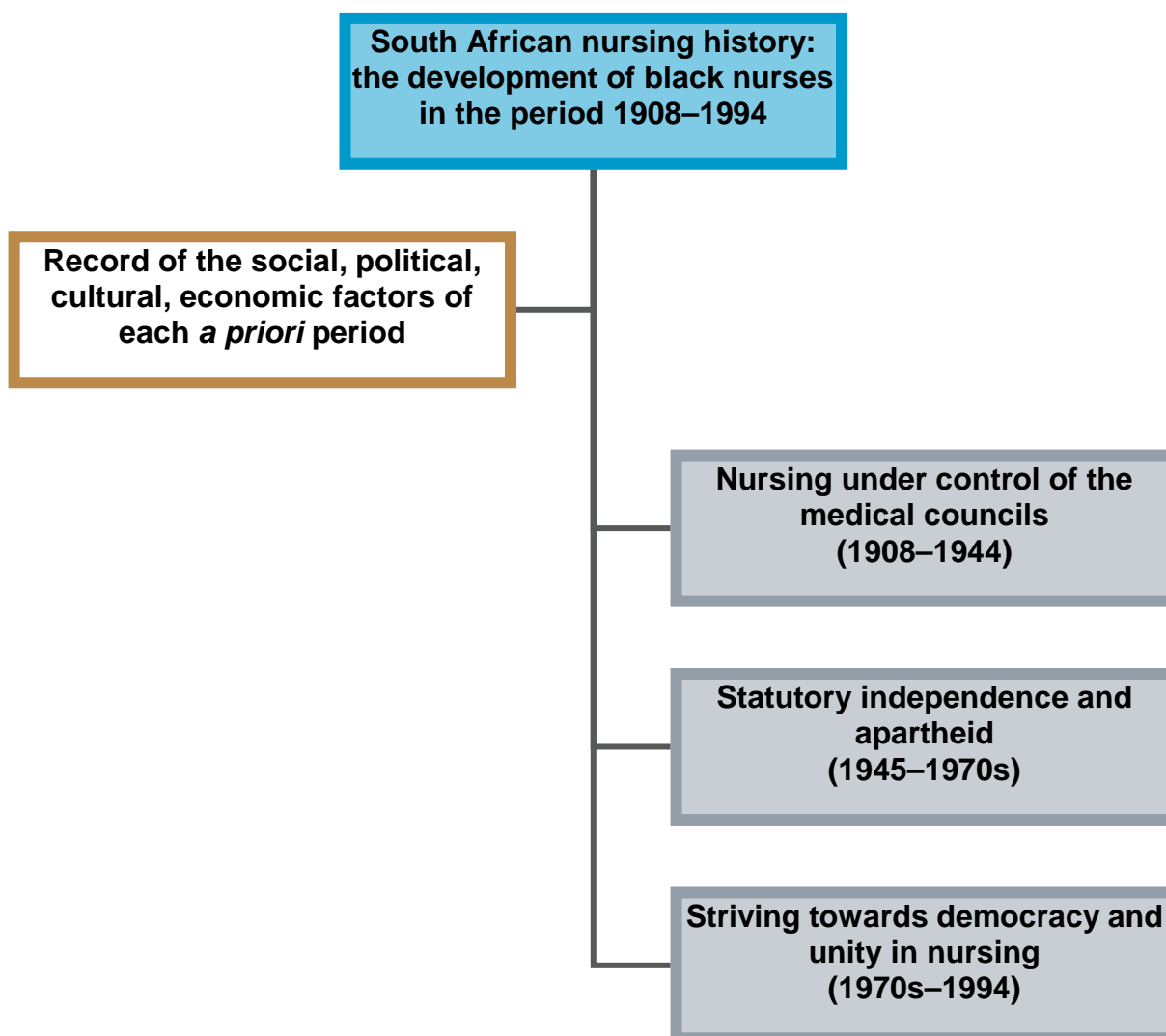


Figure 6.1 Schematic representation of the *a priori* periods discussed in this dissertation within the context of the research methodology

Within these three *a priori* periods, the researcher identified the economic, social, political and cultural factors which influenced the professional development of black nurses in South Africa.

6.3.1 Cultural factors that influenced the development of black South African nurses

During the *a priori* period 1908–1944, cultural practices required African women to marry early and accept domestic responsibilities. Furthermore, only married women could care for the sick in the community. This was the opposite of what was practised by Western nurses: they isolated themselves by joining religious orders, remained unmarried and did not participate in traditional domestic life. This provided Western women with independence and the opportunity to focus on a career. Therefore only unmarried women were allowed to train with the British nurses in mission hospitals (Marks 1994:86–88; Searle 1987:21). This difference between African and Western customs prevented the early entry of black women into professional nursing.

Historically, especially during the first two *a priori* periods, cultural taboos and traditional African beliefs also greatly influenced the entry into nursing. Young novice nurses were expected to study anatomy and physiology in the classroom and, in practice, come into contact with blood. From an African viewpoint, these biological concepts of Western health care were difficult to accept and ultimately contributed to the high attrition rate.

The Western-styled health environment, with its emphasis on independent decision-making, continued to contribute to the high dropout rate that was evident as late as the 1970s–1994. In traditional African culture, the male elders in the community were the decision-makers and it was culturally unacceptable for young females to fulfil this role. Yet, in the Western health care setting, young professional nurses were required to make independent nursing diagnoses and plan appropriate nursing care for their patients. This difference between African and professional nursing practice placed young black nurses in situational conflict and created the notion that black nurses were reluctant to make patient related decisions.

In the last *a priori* period, black women were readily able to enter the workplace (even as married women) and pursue a professional career. However, culturally they were still expected to perform most of the domestic duties, with little or no assistance from their husbands. The burden of full-time nursing and domestic duties was a heavy one.

6.3.2 Socio-economic factors that influenced the development of black South African nurses

The British social class system of the early nineteenth century, combined with the power relationships evident in the Victorian family structure, had a profound influence on South African nurses. Professional nursing was in its infancy and British nurses attempted to increase the status of nursing as a profession by allowing only educated ladies from the higher social classes to train as nurses. The class conscious British considered black South Africans as poor and uneducated and therefore of a lower class. The British nurses' insistence on training only ladies hampered the entry of black women into Western-styled nursing.

Only a few Western educated, African "ladies" complied with the requirements. These women experienced a dual position in status. Because of their formal education and entry into a profession, among black people they represented an educated, social elite. Yet, from a Western point of view they had a low social status due to their gender, race and limited formal education.

During and after WW II (1939–1945), the need to train more black nurses became urgent due to a number of interrelated factors. White nurses were drafted into the South African military forces to provide care to wounded soldiers. Up to that point in time, the rate at which black nurses were being trained was insufficient. Therefore when most of the trained nurses left to care for soldiers in overseas field hospitals, a severe nursing shortage occurred within South Africa's borders. Simultaneously, poor housing and unsanitary conditions, due to the effects of rapid urbanisation, led to a decline in the health of the largest portion of the South African population (black people). Despite their continued use of traditional healing practices, large numbers of black people also began using the Western health care system more frequently, thereby necessitating the need for black nurses to care for these patients. The presence of black nurses, who were familiar with the patients' culture and language, in the hospitals was also a motivating factor in black people utilising the Western health care system more frequently. Finally, the need to train more black nurses was driven by the government's policy of separate development which started having an influence on the nursing profession.

The severe shortage of nurses, the limitations set on the nursing contributions made by married women, combined with SATNA's efforts to establish nursing as a profession, culminated in the establishment of the SANC on 6 June 1944 with the promulgation of the Nursing Act 45 (of 1944). The first South African Nursing Act did not contain any reference to race.

The socio-economic problems due to rapid urbanisation, the declining health of the African population, and the duality in social status of black nurses prevailed in the *a priori* period 1970s–1994.

6.3.3 Political factors that influenced the development of black South African nurses

The *a priori* period 1908–1944 was marked by unrest and war. After the Second Anglo-Boer War (1899–1902), South Africa became a British Colony, functioning within the British notions of class and gender. This class system (with its implications of race) led to the practice of separate development being promoted and questions being raised about the practice of white nurses caring for black patients.

A debate commenced in 1912 about allowing the training of a less qualified black nurse only reached its conclusion 40 years later. Given the small number of black women who complied with the educational requirements, entry into nursing training was retarded while the debate continued. The practice of allowing white student nurses first access to training opportunities in hospitals also limited the number of black nursing candidates. Finally, the pass law of 1934 prohibited the movement of black women to the cities, where the larger training hospitals were located. As a result, the training of black nurses made slow progress and would only gain momentum after WW II (1939–1945).

Nursing training under the medical councils had no racial exclusions. However, the black women who were successful in entering the field of nursing were excluded from all the early efforts to establish nursing as a recognised profession. They were not included in the efforts of the SATNA to position nursing representatives on the medical councils, nor were they allowed to be members of SATNA. In reaction to their exclusion, black nurses created their own professional organisation, the BTNA in 1932.

Apartheid doctrine required that black nurses care for black patients within the Western health care system. Therefore, the policy of separate development, which culminated in the system of apartheid in later years, stimulated the development of black professional nursing and contributed to their growth in numbers. This is illustrated by the fact that there were only 200 registered black nurses in South Africa in 1940. By 1959, this number on the register of SANC had increased to 4 633 (Samson 1978:48, 51; Searle 1972:280). Ironically, the policy of apartheid also created barriers which hampered the entry of black women into the profession. The pass laws limited black women's ability to travel and reside in urban areas close to the training hospitals.

The apartheid system's negative influence on nursing was especially evident in the racially specific Nursing Act (69 of 1957) because the Act formally divided nurses into groups based on race. This contributed to SANA resigning as a member of the ICN in 1973, thereby isolating South African nurses from the international nursing community. More importantly, the Act limited black nurses' contributions to nursing leadership and decision-making processes. This racial differentiation continued until 1978 when Nursing Act 50 (of 1978) created a multiracial SANC, albeit still under white control.

The *a priori* period 1970s–1994 was dominated by dramatic events in the South African political landscape. Political organisations such as the ANC opposed the system of apartheid, and civil disobedience made the country socially unstable. International boycotts hampered the country's economic growth. These factors led to the apartheid system being gradually relaxed and eventually abandoned. South African nursing was influenced by these changes.

Compulsory membership of SANA ended in 1993 with the amendment of the Nursing Act (45 of 1944). This amendment made it possible for nurses to join trade unions and participate in strike action for the first time since the formation of the SANC and SANA in 1944.

By 1994, continuous changes to the SANC Board and the SANA constitution had the desired effect. Black nurses were gaining professional freedom (albeit gradually) and the South African nursing profession moved from being politically, socially and

economically isolated to becoming members of international organisations such as the WHO and the ICN.

6.3.4 Educational factors that influenced the development of black South African nurses

In the early decades of the nineteenth century, formal education was an unknown concept in African culture. African people were introduced to the concept by means of the missionary schools, where tuition was provided in English. Schooling was not cost-free and therefore few black parents could afford it. These factors, combined with the cultural practice of giving boys preference in attending school, prevented young black women from receiving the education they required to enter nursing. This point is illustrated by the fact that only 6% of African women were able to read and write when Cecilia Makiwane commenced her nursing training in 1908 (Baloyi 2004:44, 63; Breier et al 2009:15; Mashaba 1995:12, 26; Searle 1972:270–271).

In the *a priori* period 1944–1970s, one of SANC's tasks was to establish an effective nursing training system in South Africa. Because of the severe nursing shortage and the policy of separate development, the growing need for black nurses was identified as urgent. Training was, however, hampered by a combination of educational and cultural barriers. Nursing also had its own inherent barriers.

In the post-WW II years (1948–1949), cultural practices similar to those of the previous *a priori* period, continued to give preference to the education of boys, rather than to that of girls. The latter, who did attend secondary school, left at an early age (before completing Grade 12) in order to take up domestic roles. These factors limited the number of black girls who had the requisite secondary education to commence nursing training.

This small pool of potential nursing candidates became even smaller when one considers that young black women had a choice (albeit limited) as to which profession they wished to join: nursing or teaching. Teaching was favoured by most of the students, partly because working conditions and remuneration were better than in nursing and the training less strenuous. Teaching was also the safer option for many young girls as it did not challenge the cultural taboos related to blood, the deceased,

and the unfamiliar concepts of anatomy and physiology. As recently as the 1990s, nursing and teaching remained the primary professional career choices available to black South African women.

Despite the urgent need to train black professional nurses, their numbers grew slowly because only a small number of training posts were available and not all students completed their training programme. Large numbers of black nursing students dropped out mainly due to poor academic performance. Once again, the factors evident in the first *a priori* period (1908–1944), notably that of a poor secondary education, posed a problem for black nursing candidates in the second half of 1945–1970s, as well as in the third *a priori* period. Black students in particular were hampered by their limited access to and/or mastery of scientific subjects. As the Nursing Act (69 of 1957) had raised the required entry levels for nursing and made nursing curricula more scientific, large numbers of potential black nursing candidates were prevented from entering. Additionally, nursing lectures were presented in English – a language which most candidates had not learnt to master during their secondary education years.

In the later decades of the nineteenth century, South African politics adversely influenced the black education system and hampered the entry of black candidates into the nursing profession. In the 1970s and early 1980s, a shortage of well-equipped classrooms and trained science and mathematics teachers prevailed due to the government's limited support for the development of an adequate black school system. Of the few pupils who did attend school, many left before completing Standards 9 and 10 (Grades 11 and 12). Despite efforts to improve the situation, these conditions prevailed into the early 1990s.

During the last two *a priori* periods, the South African black community considered political freedom to be more important than education. School boycotts frequently interrupted the schooling system in black communities, which created another barrier for nursing candidates because they did not acquire the knowledge which could assist them to excel or, at times, succeed in the formal, scientific nursing courses. This lack of secondary educational skills hampered the development of black nurses, even at post-basic university training level.

Cultural factors also hindered the educational success of black nursing candidates. The nursing curriculum with its Western teaching style (the written word, lectures and emphasis on critical thinking skills) was not well suited to the learning style of the black student, which was largely oral in nature and related to story-telling. In addition, most of the scientific nursing practice taught represented the Western perception of health with its focus on biological parameters. Thus African nursing students were required to provide a form of health care based on Western principles to their African patients. The individual decision-making skills expected from professional nurses posed difficulties for young black nurses as they were raised in a culture where decisions were left to the elders. These are merely a few of the barriers identified. These cultural barriers necessitated the presence of nurse educators who were schooled in the universals of culture and education.

The political, educational and cultural factors mentioned in this chapter hampered the recruitment and retention of nursing candidates into modern nursing. It also placed a great burden on the shoulders of the nurse educator who not only had to teach the content of the nursing course, but also had to accommodate the lack of secondary education academic skills. This prompted Mashaba (1986b:399) to state: “If a tutor did a good job of all this she would be more of a magician than a tutor”.

The dropout rate from nursing courses gradually declined in the 1970s–1980s. The majority of nursing candidates were lost in the first year of training due to the ‘foreign’ language of education, the need for embedded scientific knowledge, poor study habits, criticism from ward staff, the high expectations of nurse educators, the candidates’ real interest in nursing (26% of those who dropped out were not interested in nursing), and social issues such as early marriage, and the distances from nursing education institutions. However, a greater dropout rate was recorded in 1990 and 1992. Manzini (1998:244–245) provides a socio-political explanation: “... the democratic process was new to most South Africans and it was therefore widely misunderstood to mean freedom without responsibility, which could contribute to the drop out”. Thus a need for student councillors who could guide students, not only with regard to subject and career choices, but also with regard to life in a democratic South Africa, was identified. Table 6.1 provides a summation of the conclusions about the factors which influenced the professional development of black South African nurses during the *a priori* periods.

Table 6.1 Factors influencing the professional development of black South African nurses: 1908–1994

Factors/a priori period	Summative conclusions
CULTURAL	
1908–1944	Early marriage and domestic responsibilities. African young women may not care for the sick. Western view: only unmarried women trained as nurses.
1945–1970s	Similar to 1908–1944. To a limited extent: married women allowed. Cultural taboos re blood and dead bodies, anatomy and physiology.
1970s–1994	Mostly responsible for domestic tasks. Little assistance from male partners. Western-styled health environment contributes to reality shock and high dropout rate.
SOCIO-ECONOMIC	
1908–1944	Victorian notions of control: role of men (doctor), woman (nurse) and child (patient). British social class system. Education ensured high social status in black community. Economic class and race ensured low status in Western health system.
1945–1970s	Increased urbanisation. The health of the African population declined. Due to WW II: a nursing shortage. Education ensured high social status in black community. Economic class and race ensured low status in Western health system.
1970s–1994	Increased urbanisation. The health of the African population declined. Education ensured high social status in black community. Economic class and race ensured low status in Western health system.
POLITICAL	
1908–1944	Racial component added to the Victorian class system. Policy of segregation.
1945–1970s	Apartheid policy necessitated an increase in the number of black nurses. Apartheid policy limited access to training and nursing posts. Nursing Act (69 of 1957)
1970s–1994	Gradual move away from apartheid laws. Political instability: strikes and boycotts.
EDUCATIONAL	
1908–1944	Formal education: culturally unknown concept. Limited access to formal schooling. Cost of formal schooling. Tuition in foreign language: English. Boys given preference. Only girls allowed to enter nursing training. Nursing: high educational entry requirements.
1945–1970s	Limited access to schooling. Boys given preference. Tuition in foreign language: English. Educated girls had career options: teaching or nursing. Teaching preferred. SANC established nursing profession and raised entry requirements. High student dropout rate.
1970s–1994	Boycotts and strikes limited access to secondary education. Secondary education: students did not master science subjects and/or the English language. Teachers not adequately trained. Limited access to educational resources. High nursing entry levels to accommodate tertiary education standards. Learning style of black students. High dropout rate from nursing course due to lack of science and language skills.

6.4 SCOPE AND LIMITATIONS

The research underlying this dissertation focused on the professional development of black nurses in South Africa. It did not investigate the position of black nurses elsewhere in Africa, nor did it focus on the status of coloured and Indian nurses in South Africa. The research was also limited to the historical period reviewed. Only events that had an influence on the development of black South African nurses in the period 1908–1994 were considered. No events after 1994 were included as the period deserves specific and detailed attention from South African nurse historians.

It is the fear of the novice historian that a valuable source of data might not have been found and included in the writing of the narrative. Issues that constrained the researcher included the time available for travel to research wider aspects in the literature (which can be costly in historical research), as well as the boundaries set by the scope of a master's dissertation. However, the purpose of this dissertation was to ask, answer and record one historical question within the timeframe and limitations set by current reality. The dissertation is by no means intended to provide a definitive answer to a question, but rather to encourage fellow nurses to further explore their uniquely South African professional history. Knowledge of where we came from will make us proud, stimulate our curiosity, and give us direction and courage to face the future with determination and pride.

6.5 RECOMMENDATIONS

The value of history lies in its potential to influence the present. On the basis of the conclusions reached in this dissertation, the following recommendations are made:

6.5.1 Recommendations for further historical research

Few South African nurse historians have taken up the challenge of analysing and recording South African nursing history. Themes that should be explored include:

- South African nursing historians should provide the profession with a historical analysis of nursing organisations' protocols and practices, thereby providing insight into planning the future.

- It is recommended that historical case studies of the large training colleges, such as Lovedale College and Baragwanath Nursing College, be conducted to provide historical clarification for current educational systems and protocols.
- More recent history warrants a study of SANA's transformation into the DENOSA, its relations with trade unionism, and the role of SANC in guiding the nursing profession through this period of transition.
- The value of history in developing the professional socialisation of novice nurses should be explored as it creates philosophical foundations, encourages ethical behaviour, develops critical thinking skills, and awakens a willingness to reflect.
- Case studies of nurse leaders such as Jane McLarthy, the first Matron-in-Chief of Baragwanath Hospital, and Albertina Sisulu, considered the Mother of the Nation, should be conducted as they inspire and encourage reflection on the challenges faced, mistakes made, and the triumphs achieved.
- Similar to the current study, historical inquiries should be conducted to research the professional development of Indian, coloured and male nurses in South Africa and the social, political, economic and cultural factors influencing the professional development of black nurses after 1994.

6.5.2 Recommendations regarding teaching strategies

- As teaching is presented in English, which in most cases is a second or third language for students, nurse educators must consider and accommodate the students' linguistic ability to communicate in theoretical and practical assessments.
- Cultural assessments of students related to aspects such as verbal and non-verbal communication, space, touch and concepts of time are valuable in creating awareness of the different cultures present in one class.
- Cultural awareness related to students and self-awareness by the nurse educator will influence the teaching approach when ethical and religious topics such as abortion and care of the deceased are discussed.
- Teaching strategies such as the clarification of values, role play and group discussions should be used to create an understanding of the multicultural environment which is the clinical setting.

6.5.3 Recommendations regarding cultural sensitivity in the health care system

- Cultural diversity training should be available for students, nurse educators and health care practitioners in general.
- Cultural protocols could be developed to accommodate diverse religious and cultural practices in the health care environment.
- Nursing practice should be sensitive to diverse cultural health perceptions among nurses and patients by allowing different approaches to the types of health education provided.
- Health care professionals should be sensitive to diverse religious and health practices by developing protocols which accommodate a fusion of Western and traditional African health practices to occur at the patient's bedside.
- Information leaflets/charts regarding the universals of culture and mainstream religions should be available in all clinical areas to ensure culturally sensitive care. These charts could contain information on eating habits, bathing practices, care of the deceased, or birth practices.
- Given the cultural background of black nurses, the nursing profession should identify methods of assisting novice registered nurses to develop independent decision-making skills, thereby assuming the role of the "elders" in patient care decisions.
- Nursing education institutions should plan events such as cultural days, field trips to cultural villages, and lectures by experts in cultural diversity which allow educators and students to celebrate their cultural diversity.

6.5.4 Recommendations for further research

- Nurse researchers should identify similarities and/or differences between the reasons contributing to the current dropout rate and those historically identified reasons in order to prevent repetitive recruitment and retention mistakes.
- Further research should be conducted into the flexibility of nursing admission requirements in accommodating the historical backgrounds of all applicants.
- Nurse researchers should investigate whether the perceived critical thinking skills gap is related to the cultural practice of not criticising oneself or to the secondary educational system that students stem from.

- The differences in the historical and current socio-economic position of nurses could be explored in order to inform current labour-related issues and clarify perceived changes in the status and image of nurses.
- Given the lack of inclusive sources on the history of black nurses, curricula related to the history of nursing are insufficient. It is therefore recommended that curricula related to the history of nursing should include reference to all cultural groups present in South African nursing.
- Based on the history of the development of black nurses a study should be conducted into retention strategies for students from previous and current disadvantaged academic backgrounds.

6.5.5 Recommendations regarding recruitment and retention of students

Given the reasons for the high attrition rate observed in the second and third *a priori* periods (see sub-section 6.3.4 of this chapter and Table 6.1), as recorded in the research findings, and the importance of learning from past experience, the following recommendations are made:

- The nursing profession should inform prospective students about the scope and the practical reality of nursing by using simulation labs and job shadowing during school holidays as a stimulating means of introduction.
- Nurse educators should familiarise themselves with the subject content of secondary school sciences in order to have insight into the first-year nursing candidates' levels of embedded knowledge.
- Prospective students' academic interest in science subjects can be enhanced by presenting film footage/shows, exhibitions and discussion forums to demonstrate how science actually comes alive in the nursing profession.
- Nursing education institutions should be actively involved in recruitment processes by participating in school career days, take a girl child to a working day in the hospital, to science fairs, as well as exposing her to career presentations in the printed media, e.g. newspapers.
- All training institutions should have reliable and well-researched selection policies and procedures.

- Best practices for early intervention and continuous academic support of students should be identified and implemented.

6.6 CONCLUSION

Historically, the development of professional black nursing in South Africa chronicles the courageous struggles of men and women in the face of overcoming overwhelming odds. Culturally, they had to adapt to a Western dominated health view, with its focus on science. Educationally, they had to master a high level of formal Western education presented in a 'foreign' language (English) in order to comply with the requirements for entry into professional nursing. Socially, they had to adapt to being regarded as the elitist middle class in the black community, but marginalised black persons in the white-dominated work place. This marginalised position was due to the system of so-called separate development which dominated life in South Africa during the entire period discussed in this dissertation – first evident in the days of being a union under British domination; then formalised during the days of political apartheid. Cecilia Makiwane was the first black woman to enter the domain of professional nursing. She was followed by an ever-increasing stream of remarkable black men and women who today represent one of the largest professional groups in South Africa.

The final word belongs to Professor Grace Mashaba who quotes Mahler in the last page of her book *Rising to the Challenge of Change* (1995:138):

To look forward with vision, it is wise to glance backward with perception – not to be bound by history; not to blame ourselves or our predecessors, but to learn lessons as a springboard to the future.

LIST OF REFERENCES

- Adderly-Kelly, B. 2008. Looking back – moving forward: A future worthy of our past. *Association of Black Nursing Faculty Journal* 19(1):4–7.
- Adhikari, M. 2006. Industrialisasie en die herlewing van swart politiek in die 1940's, in *Keerpunte in die geskiedenis boek 4: Industrialisasie, landelike verandering en nasionalisme*, redakteur AM Grundlingh. Kaapstad: Tafelberg Uitgewers:24–44.
- A Native nurse in her location. 1921. *The Christian Express*, December: 190.
- Baloyi, CR. 2004. The role of the state in the establishment of a culture of learning and teaching in South Africa (1910–2004). Unpublished PhD (Education) thesis. University of South Africa, Pretoria.
- Beal, B. 1970. Bantu nursing. *American Journal of Nursing* 70(3):547–550.
- Beck, RB. 2000. *The history of South Africa*. Westport, CT: Greenwood Press.
- Bigbee, JL. 2008. The relationship between nurse to population ratio and the state health ranking. *Public Health Nursing* 25(3):244–252.
- Bonner, P. 2006. Die Soweto-opstande van Junie 1976, in *Keerpunte in die geskiedenis boek 5: Mense, plekke en apartheid*, redakteur Z Jaffer. Kaapstad: Tafelberg Uitgewers:30–41.
- Bostridge, M. 2008. *Florence Nightingale: The woman and her legend*. London: Penguin Books.
- Boyd, NM & Bright, DS. 2007. Appreciative inquiry as a mode of action research for community psychology. *Journal of Community Psychology* 35(8):1019–1036.
- Breier, M, Wildschut, A & Mgqolozana, T. 2009. *The practice of nursing in a new era*. 6th edition. Cape Town: Human Sciences Research Council.
- Brink, H, Van der Walt, C & Van Rensburg, G. 2006. *Fundamentals of research methodology for health care professionals*. 2nd edition. Cape Town: Juta.
- Brink, PJ & Wood, MJ. 1998. *Advanced design in nursing research*. 2nd edition. Thousand Oaks, CA: Sage.
- Brits, JP. 1993. Part 2: 1919–1934, in *South Africa in the 20th century*, edited by BJ Liebenberg & SB Spies. Pretoria: Van Schaik:141–266.
- Burger, M. 1992. *Verwysingstegnieke*. 8ste hersiening. Pretoria: Universiteit van Suid-Afrika.
- Burns, N & Grove, SK. 2009. *The practice of nursing research*. 6th edition. St Louis, MO: Saunders Elsevier.
- Buthelezi, MSTM. 2004. *African nurse pioneers in Kwazulu-Natal: 1920–2000*. Madadeni: Amashenge.

Cheater, AP. 1974. A marginal elite? African registered nurses in Durban, South Africa. *African Studies* 33:143–158.

Concise Oxford English Dictionary. 2004. [CD ROM]. 11th edition. Available: Oxford University Press, UK.

Cutcliffe, JR & McKenna, HP. 1999. Establishing the credibility of qualitative research findings: The plot thickens. *Journal of Advanced Nursing* 30(2):374–380.

Davies, C (ed). 1980. *Rewriting Nursing History*. Chippenham, Anthony Rowe Ltd.

Dempsey, PA & Dempsey, AD. 1996. *Nursing research text and workbook*. Boston, MA: Little, Brown and Company.

Dickens, C. 1992. *Oliver Twist*. Hertfordshire: Wordsworth.

Du Preez, M. 2006. Die wonderwerk van die oorgang, in *Keerpunte in die geskiedenis boek 6: Onderhandelings, oorgang en vryheid*, redakteur F du Toit. Kaapstad: Tafelberg Uitgewers:22–37.

Du Preez, SJ & Brannigan, E. 1991. The South African Nursing Association, in *State of the art of nursing: A centenary publication*, edited by LR Uys, HHM Uys & WJ Kotze. Pretoria: South African Nursing Publication:33–51.

Ehlers, VJ. 2000. Nursing and politics: A South African perspective. *International Nursing Review* (47)2:74–82.

Field, S. 2006. Politiek en bewuswording in Kaapse gemeenskappe, 1980–1985, in *Keerpunte in die geskiedenis boek 5: Mense, plekke en apartheid*, redakteur Z Jaffer. Kaapstad: Tafelberg Uitgewers:42–51.

Forum for Professional Nurse Leaders. 2011. *Newsletter*, Autumn. From: <http://www.fpnl.co.za/newsletters/Autumn2011.pdf> (accessed 28 June 2012).

FPNL. See Forum for Professional Nurse Leaders.

Gaitskell, D. 1982. Women, religion and medicine in Johannesburg between the wars. Paper presented at the African Studies Seminar, 19 August, University of the Witwatersrand, Johannesburg.

Ghaye, T. 2007. Is reflective practice ethical? (The case of the reflective portfolio). *Reflective practice* 8(2):151–162.

Galgano, MJ, Arndt, JC & Hyser, RM. 2008. *Doing history, research and writing in the digital age*. Boston, MA: Thomson Wadsworth.

Giordano, BP. 1996. We must know where perioperative nursing has been to know where it is going. *Association of Perioperative Registered Nurses (AORN) Journal* 64(2):178. From: <http://www.aornjournal.org/article/PIIS0001209206631451/fulltext> (accessed 8 April 2010).

- Glass, LK. 1998. Historical research, in *Advanced design in nursing research*. 2nd edition, edited by PJ Brink & MJ Wood. Thousand Oaks, CA: Sage:356–370.
- Graig, BL. 1994. Memories and the memorial: Developing and managing nursing archives for Canada. *Canadian Bulletin of Medical History* 11:237–248. From: <http://www.cbmh.ca/index.php/cbmh/article/view/317> (accessed 8 April 2010)
- Grundlingh, A. 1987a. *Fighting their own war: South African blacks and the First World War*. Johannesburg: Ravan Press.
- Grundlingh, A. 1987b. The impact of the First World War on South African blacks, in *Africa and the First World War*, edited ME Page. London: MacMillan:54–80.
- Grundlingh, AM. 1993. 1934–1948, in *South Africa in the 20th century*, edited by BJ Liebenberg & SB Spies. Pretoria: Van Schaik:267–313.
- Gumbi, RV. 1991. The challenge of the future, in *State of the art of nursing: A centenary publication*, edited by LR Uys, HHM Uys & WJ Kotze. Pretoria: South African Nursing Publication:161–164.
- Hargreaves, J. 2008. The under-used resource of historical research. *Nurse Researcher* 15(3):32–44.
- Hartshorne, KB. 1974. Bantu education. *South African Medical Journal* 48(60):2517–2519.
- Helmstadter, C. 2009. Shifting boundaries: Religion, medicine, nursing and domestic service in mid-nineteenth-century Britain. *Nursing Inquiry* 16(2):133–143.
- Holmes, CA. 2008. Historical enquiry and understanding our past. *Contemporary Nurse* 30:101–105.
- Holst, H. 2011. *McCord Hospital: Few achievements in the last 100 years*. From: https://www.givengain.com/cgi-bin/giga.cgi?cmd=cause_dir_news_item&cause_id=1285&news_id=56953 (accessed 28 August 2011).
- Horwitz, S. 2007. ‘Black nurses in white’: Exploring young women’s entry into the nursing profession at Baragwanath Hospital, Soweto, 1948–1980. *Social History of Medicine* 20(1):131–146.
- Hotz, SC. 1988. Nurses as agents for social change, in *Women in health, Proceedings of the conference hosted by the Department of Nursing, University of Cape Town, Cape Town, 9–11 September 1987*, compiler S Clow. Observatory: University of Cape Town Printing Services:269–274.
- Hunt, NB. 1991. The South African Nursing Association, in *State of the art of nursing: A centenary publication*, edited LR Uys, HHM Uys & WJ Kotze. Pretoria: South African Nursing Publication:1–16.
- Hurst, K. 2009. Nurses in Florence Nightingale’s day worked “until they dropped”. *Nursing Standard* 23(18):15.

- Kitshoff, S. 2011. Zuma sê verpleegsters in hul wit uniforms het net daardie 'ietsie'. *Rapport*, 10 April. From: <http://152.111.1.87/argief/berigte/rapport/2011/04/11/RH/4/polZuma.html> (accessed 28 June 2012).
- Kruman, MW. 1985. Historical method: Implications for nursing research, in *Qualitative research methods in nursing*, editor MM Leininger. Philadelphia, PA: WB Saunders:109–118.
- Lancaster, LC. 2004. When generations collide: How to solve the generational puzzle at work. A presentation for The Management Forum Series, 17 March. From: www.oregonjobs.org/DAS/HR/LO/docs/WhenGenerationsCollide.pdf (accessed 14 April 2010).
- Lewenson, SB & Hermann, EK (eds). 2008. *Capturing nursing history*. New York: Springer.
- Liebenberg, BJ. 1993. 1966–1991, in *South Africa in the 20th century*, edited by BJ Liebenberg & SB Spies. Pretoria: Van Schaik:421–540.
- Lovedale news. 1919. *The Christian Express*, October: 159.
- Luthuli, ND, Masiea, SE & Zuma, LC. 1992. The hurdles faced by black students. *Nursing RSA* 7(2):30–33.
- Makgoba, MW. 2006. Mense, politiek en ideologie, in *Keerpunte in die geskiedenis boek 5: Mense, plekke en apartheid*, redakteur Z Jaffer. Kaapstad: Tafelberg Uitgewers:14–29.
- Makhaya, MAS. 1988. Meeting the needs of the disadvantaged student, in *Women in Health, Proceedings of the conference hosted by the Department of Nursing, University of Cape Town, Cape Town, 9–11 September 1987*, compiler S Clow. Observatory: University of Cape Town Printing Services:159–162.
- Maloka, E. 2006. Die vrugte van vryheid, in *Keerpunte in die geskiedenis boek 6: Onderhandeling, oorgang en vryheid*, redakteur F du Toit. Kaapstad: Tafelberg Uitgewers:52–64.
- Mandela, NR. 1995. *Long walk to freedom*. London: Abacus.
- Manzini, HN. 1998. Student nurses drop out. Unpublished PhD (Nursing Science) thesis. University of South Africa, Pretoria.
- Maree, K & Pietersen, J. 2010. Sampling, in *First steps in research*, editor K Maree. Pretoria: Van Schaik:172–181.
- Maree, K & Van der Westhuizen, C. 2010. Planning a research proposal, in *First steps in research*, editor K Maree. Pretoria: Van Schaik:24–45.
- Marks, S. 1991. The nursing profession and the paradox of apartheid. Paper presented at the Women and Gender in Southern Africa Conference by the Centre for African Studies, 30 January – 2 February, Durban.

Marks, S. 1994. *Divided sisterhood*. London: MacMillan.

Marks, S. 2002. British nursing and the South African war, in *Writing a wider war: Rethinking gender, race and identity in the South African war 1899–1902*, edited by G Cuthbertson, A Grundlingh & M Suttie. Cape Town: David Philip 159–185.

Mashaba, TG. 1985. The education and training of the black nurse in South Africa 1900 to 1982. Unpublished D Litt et Phil (Nursing Science) thesis. University of South Africa, Pretoria.

Mashaba, TG. 1986a. Implications of the educational system for blacks in nursing education. *Curationis* 9(3):1–4.

Mashaba, TG. 1986b. The significance of secondary school education for education and training of nurses in South Africa. *Journal of Advanced Nursing* 11(4):395–401.

Mashaba, TG. 1995. *Rising to the challenge of change: A history of black nursing in South Africa*. Cape Town: Juta.

McDowell, WH. 2002. *Historical research: A guide*. London: Pearson Education.

Mdepa, W & Tshiwula, L. 2012. Student diversity in South African higher education. *Widening Participation and Lifelong Learning* 13 (special issue):19–33.

Medway's Pocket Dictionary. 2003a. Sv “gain” and “obtain”. St Albans: Medway.

Medway's Pocket Dictionary. 2003b. Sv “history”. St Albans: Medway.

Medway's Pocket Dictionary. 2003c. Sv “European”. St Albans: Medway.

Medway's Pocket Dictionary. 2003d. Sv “African”. St Albans: Medway.

Mellish, JM. 1990. *A basic history of nursing*. 2nd edition. Durban: Butterworth.

Mellish, JM, Brink, HIL & Paton, F. 2009. *Teaching and learning the practice of nursing*. 4th edition. Sandton: Heinemann.

Mellish, JM, Oosthuizen, A & Paton, F. 2010. *An introduction to the ethos of nursing*. 3rd edition. Sandton: Heinemann.

Mhlongo, TP. 1998. Towards culture care nursing education: A study of TG Mashaba's transcultural themes. Unpublished D Litt et Phil thesis. University of South Africa, Pretoria.

Mortimer, B & McGann, S (eds). 2005. *New directions in the history of nursing*. London: Routledge.

Muller, CJF (red). 1985. *Vyfhonderd jaar Suid-Afrikaanse geskiedenis*. Pretoria: Academica.

NHS Foundation Trust. [Sa]. *University College London Hospitals*. From: <http://www.uclh.nhs.uk/aboutus/whoweare/archives/Pages/Timeline1800-1899.aspx> (accessed 15 May 2011).

Nieftagodien, N. 2006. Die opstande in die townships, September–November 1984, in *Keerpunte in die geskiedenis boek 5: Mense, plekke en apartheid*, redakteur Z Jaffer. Kaapstad: Tafelberg Uitgewers:52–66.

Nieuwenhuis, J. 2010a. Analysing qualitative data, in *First steps in research*, edited by K Maree. Pretoria: Van Schaik:99–122.

Nieuwenhuis, J. 2010b. Qualitative research designs and data gathering techniques, in *First steps in research*, edited by K Maree. Pretoria: Van Schaik:69–97.

Nursing Acts. See South Africa.

Oberlin College Archives. [Sa]. *RG 30/349 – The Bridgman Family Papers*. From: <http://www.oberlin.edu/archive/holdings/finding/RG30/SG349/biography.html> (accessed 23 September 2011).

Olivier, M. 1984. Didakties-andragogiese probleme in die opleiding van swart studente in die aanvullende gesondheidsdienste. MEd (Didaktiek)-tesis. Universiteit van Suid-Afrika, Pretoria.

Pakenham, T. 1992. *The Boer War*. London: Abacus.

Phelps, RP; Sadoff, RH; Warburton, EC & Ferrara, L. 2005. *A guide to research in music education*. Maryland, Lanham, The Scarecrow Press.

Polit, DF & Beck, CT. 2008. *Nursing research: Generating and assessing evidence for nursing practice*. 8th edition. Philadelphia, PA: Lippincott Williams & Wilkins.

Potgieter, E. 1992. *Professional nursing education 1860–1991*. Pretoria: Academica.

Rispel, L & Schneider, H. 1989. *Professionalisation of South African nursing: Who benefits?* Paper no 17. Johannesburg: The Centre for the Study of Health Policy, University of the Witwatersrand.

Samson, JP. 1978. Nursing education and the black nurse – an overview. *Curationis* 1(1):47–55.

SANA. See South African Nursing Association.

SAVV. See Suid-Afrikaanse Verpleegstersvereniging.

Schultheiss, K. 2010. Imperial nursing: Cross-cultural challenges for women in health professions: A historical perspective. *Policy, Politics and Nursing Practice* 11(2):151–157.

Searle, C. 1972. *Die geskiedenis van die ontwikkeling van verpleging in Suid-Afrika 1652–1960*. Pretoria: Die Suid-Afrikaanse Verpleegstersvereniging.

- Searle, C. 1975. Some aspects of nursing education, in *South African Nursing Association Contemporary Series No 1*. Pretoria: The South African Nursing Association:35–42.
- Searle, C. 1987. Career woman! (Henrietta Stockdale). *Nursing RSA Verpleging* 2(4):21–22.
- Searle, C. 1988. *Aspects of selected nursing issues*. Durban: Butterworths.
- Searle, C. 1991. *Towards excellence: The centenary of state registration for nurses and midwives in South Africa 1891–1991*. Durban: Butterworths.
- Scher, DM. 1993. 1948–1966, in *South Africa in the 20th century*, edited by BJ Liebenberg & SB Spies. Pretoria: Van Schaik: 321–420.
- South Africa. 1944. *Nursing Act No. 45 of 1944*. Cape Town: Union Gazette Extraordinary.
- South Africa. 1951. *Medical, Dental and Pharmacy Act No. 13 of 1928*. The Union Statutes 1910–1947. Cape Town: Government Printer.
- South Africa. 1957. *Nursing Act No. 69 of 1957*. Cape Town: Union Gazette Extraordinary.
- South Africa. 1978. *Nursing Act No. 50 of 1978*. Cape Town: Government Gazette.
- South African History Online. [S.a.]a. *Historical overview of black resistance 1932–1952*. From: <http://www.sahistory.org.za/article/historical-overview-black-resistance-1932-1952> (accessed 24 September 2011).
- South African History Online. [S.a.]b. *The liberation struggle*. From: <http://www.sahistory.org.za/article/liberation-struggle-south-africa-42> (accessed 24 September 2011).
- South African History Online. [S.a.]c. Robert Mangaliso Sobukwe. From: <http://www.sahistory.org.za/people/robert-mangaliso-sobukwe> (accessed 8 September 2012).
- South African Information Service. 1961. Nursing service for 15 million people. Fact paper 89, March. Supplement to the *Digest of South African Affairs*. Pretoria: Union of South Africa.
- South African Nursing Association. [S.a.]. *Report on nursing service and nursing education in the Republic of South Africa 1979–1983*. Pretoria: SANA.
- South African Nursing Association. 1980. *Nursing services in the Republic of South Africa 1914–1974*. Pretoria: SANA.
- South African Nursing Association. 1986. *South African nurses of distinction, Volume 1*. Pretoria: SANA.

- South African Nursing Association. 1989. *South African nurses of distinction, Volume 2*. Pretoria: SANA.
- Spies, SB. 1993. Part 1: 1900–1919, in *South Africa in the 20th century*, edited by BJ Liebenberg & SB Spies. Pretoria: Van Schaik:3–131.
- Stevenson, JC. 2007. *The auxiliary nurse's guide*. Lansdowne: Juta.
- Stommel, M & Wills, CE. 2004. *Clinical research: Concepts and principles for advanced practice nurses*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Streubert Speziale, HJ & Carpenter, RD. 2003. *Qualitative research in nursing*. 3rd edition. Philadelphia, PA: Lippincott, Williams & Wilkins.
- Suid-Afrikaanse Verpleegstersvereniging. 1975. *Verslag oor die verpleegdiens in die Republiek van Suid-Afrika en die gebied van Suidwes-Afrika*. Pretoria: SAVV.
- Suid-Afrikaanse Verpleegstersvereniging. 1978. *Verslag oor die verpleegonderwys in die Republiek van Suid-Afrika en die selfregerende gebiede*. Pretoria: SAVV.
- Suid-Afrikaanse Verpleegstersvereniging. 1990. *Verslag oor die ondersoek na die verpleegberoep 1990*. Pretoria: SAVV.
- Sweet, H. 2004. "Wanted: 16 nurses of the better educated type": Provision of nurses to South Africa in the late nineteenth and twentieth centuries. *Nursing Enquiry* 11(3):176–184.
- Sweet, H & Digby, A. 2005. Race, identity and the nursing profession in South Africa, c 1850–1958, in *New directions in the history of nursing*, edited by B Mortimer & S McGann. London: Routledge:109–124.
- The employment of native nurses. 1911. *The Christian Express*, January:2–3.
- The month. 1914. *The Christian Express* XLIV (519). January:1.
- The Internet Movie Database. c1990–2011. *Memorable quotes for Mary Poppins (1964)*. From: <http://www.imdb.com/title/tt0058331/quotes> (accessed 15 May 2011).
- The question of the nursing of natives in South African hospitals. 1907. *The Christian Express*, January:9–11.
- University of Witwatersrand, Department of Historical Papers. [S.a.]. Handwritten letter by Gloria Mamabolo, Eastern Native Township, Johannesburg. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.6. Johannesburg.
- University of Witwatersrand, Department of Historical Papers. 1932a. Letter by Dr HA Moffat, 26 July 1932. RR12/32. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 2118/32. Johannesburg.
- University of Witwatersrand, Department of Historical Papers. 1932b. Proceedings of the Conference on Training of Non-European Nurses: Avenues of Employment for

Non-European Nurses, Medical and Health Services in Native Areas, 17 June. *Records of the South African Institute of Race Relations (SAIR) Part 1*. Accession No. AD 2118\32. Johannesburg.

University of Witwatersrand, Department of Historical Papers. 1934. Minutes of 2nd Annual Meeting of the Transvaal Branch of the Bantu Trained Nurses' Association, 9 December 1934. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.6. Johannesburg.

University of Witwatersrand, Department of Historical Papers. 1935. Minutes of 3rd Annual Meeting of the Transvaal Branch of the Bantu Trained Nurses' Association, 6 December 1935. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.6. Johannesburg.

University of Witwatersrand, Department of Historical Papers. 1937. Minutes of 4th Annual Meeting of the Transvaal Branch of the Bantu Trained Nurses' Association, 24 January 1937. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.6. Johannesburg.

University of Witwatersrand, Department of Historical Papers. 1939. Minutes of Second Biennial Conference of the Bantu Trained Nurses' Association, 10–12 April 1939. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.6. Johannesburg.

University of Witwatersrand, Department of Historical Papers. 1949. Report on the Shortage of Nurses in South Africa, part II. Position in Secondary Schools Training Bantu, Coloured and Asiatic Girls, 19 January 1949. *Records of the South African Institute of Race Relations Part 1*. Accession No. AD 843/B, file 89.1.5. Johannesburg.

Van der Merwe, AS. 1999. The power of women as nurses in South Africa. *Journal of Advanced Nursing* 30(6):1272–1279.

ANNEXURE A

ETHICAL CLEARANCE FROM UNISA

ANNEXURE B

EXAMPLES OF CHECKLISTS TO CONFIRM EXTERNAL AND INTERNAL CRITICISM OF DATA SOURCES

ANNEXURE C

DECLARATION OF RESEARCHER'S ETHICAL COMPLIANCE

ANNEXURE D

REFLECTION

ANNEXURE E

EDITOR'S DECLARATION

ANNEXURE A

ETHICAL CLEARANCE FROM UNISA



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
(HSHDC)
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

Date of meeting: 17 February 2011 Project No: 3009-515-8
Project Title: South African Nursing 1908-1994: A historical perspective
Researcher: Johanna Maria Esterhuizen
Degree: MA in Health Studies Code: MPCHS94
Supervisor: Prof GH van Rensburg
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

Approved



Conditionally Approved




**Prof E Potgieter
RESEARCH COORDINATOR**


**Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES



ANNEXURE B

EXAMPLES OF CHECKLISTS TO CONFIRM EXTERNAL AND INTERNAL CRITICISM OF DATA SOURCES

Example 1: primary source

The Role of the State in the establishment of a Culture of learning and teaching in South Africa (1910–2004). Thesis for the degree of Doctor of Education. University of South Africa.

Date accessed: August 2011

✓ **Library / Archive / private collection /** ✓ **online data base:**

✓ **Primary / secondary source:**

Authenticity: ✓ **original document / copy**

Author: Baloyi, CR

Date written / published: 2004

Type: ✓ **empirical data / personal opinion / anecdotal account**

Historical documents: inclusive criteria

	Criteria	Yes	No
	Section A: Document		
1	Document is relevant to research objectives.	X	
2	Content can be verified by other sources.	X	
3	Document is clear and easy to understand.	X	
4	Language / words in document: meaning is known to the researcher.	X	
5	Evidence of alteration or missing content.		X
6	Purpose of document: publication to an audience.	X	
7	Purpose of the document: private use.		X

	Section B: Author		
1	Author's background is known.	X	
2	Author's biases and / or prejudices were considered.	X	
3	Literary style is similar to other documents by the same author.	N/A	
4	Author was removed from event – in physical / time dimension.	X	
5	Author was involved in historical event.		X
6	Events were recorded accurately (no evidence to the contrary).	X	
7	Author was willing / able to record the truth.	X	
8	In writing the document, author stands to gain personal advantage.		X

Document included in the research project: YES

Motivation: Doctoral Thesis from UNISA related to education in South Africa

Example 2: Primary, online source

RG 30/349 – The Bridgman Family Papers. From:

<http://www.oberlin.edu/archive/holdings/finding/RG30/SG349/biography.html>

Date accessed: 23 September 2011

Library / Archive / ☒ private collection (online) / online data base:

☒ Primary (online) / secondary source:

Authenticity: original document / ☒ copy

Author: Oberlin College Archives

Date written / published: [S.a.]

Type: empirical data / personal opinion / ☒ anecdotal account

Historical documents: inclusive criteria

	Criteria	Yes	No
	Section A: Document		
1	Document is relevant to research objectives.	X	
2	Content can be verified by other sources.	X	
3	Document is clear and easy to understand.	X	
4	Language / words in document: meaning is known to the researcher.	X	
5	Evidence of alteration or missing content.		X
6	Purpose of document: publication to an audience.		X
7	Purpose of the document: private use.	X	
	Section B: Author		
1	Author's background is known.	X	
2	Author's biases and / or prejudices were considered.	X	
3	Literary style is similar to other documents by the same author.	NA	
4	Author was removed from event – in physical / time dimension.		X

5	Author was involved in historical event.	X	
6	Events were recorded accurately (no evidence to the contrary).	X	
7	Author was willing / able to record the truth.	X	
8	In writing the document, author stands to gain personal advantage.		X

Document included in the research project: YES

Motivation: The Bridgmans were a missionary family in Kwazulu-Natal who were also involved in the Black Trained Nurses Association. The online archive hosts the letters written by the family.

Example 3: Primary archival source

Records of the South African Institute of Race Relations Part 1. Accession No AD 2118\32. Letter by Dr H.A. Moffat, RR12/32

Date accessed: 28 November 2011

Library / √ Archive / private collection / online data base:

√ Primary / secondary source:

Authenticity: √ original document / copy

Author: University of Witwatersrand, Department of Historical Papers

Date written / published: 26 July 1932

Type: empirical data / √ personal opinion / anecdotal account

Historical documents: inclusive criteria

	Criteria	Yes	No
	Section A: Document		
1	Document is relevant to research objectives.	X	
2	Content can be verified by other sources.	X	
3	Document is clear and easy to understand.	X	
4	Language / words in document: meaning is known to the researcher.	X	
5	Evidence of alteration or missing content.		X
6	Purpose of document: publication to an audience.		X
7	Purpose of the document: private use.	X	
	Section B: Author		
1	Author's background is known.	X	
2	Author's biases and / or prejudices were considered.	X	
3	Literary style is similar to other documents by the same author.	NA	
4	Author was removed from event – in physical / time dimension.		X

5	Author was involved in historical event.	X	
6	Events were recorded accurately (no evidence to the contrary).	X	
7	Author was willing / able to record the truth.	X	
8	In writing the document, author stands to gain personal advantage.		X

Document included in the research project: YES

Motivation: The letter reveals Dr Moffat's concern regarding the health of the African population and confirms the urgency of training black nurses. It also reflects the opinions of the nursing representatives at the 1932 conference.

Example 4: One author; books and an article

(1). *Die Geskiedenis van die Ontwikkeling van Verpleging in Suid - Afrika 1652–1960.*

(2). *Career Woman!* (Henrietta Stockdale).

(3). *Towards Excellence. The centenary of state registration for nurses and midwives in South Africa 1891–1991.*

Date accessed: June-December 2011

✓ **Library / Archive / private collection / online data base:**

Primary / ✓ **secondary source:**

Authenticity: original document / ✓ **copy**

Author: Searle, C

Date written / published: 1972, 1987, 1991

Type: ✓ **empirical data / personal opinion / anecdotal account**

Historical documents: inclusive criteria

	Criteria	Yes	No
	Section A: Document		
1	Document is relevant to research objectives.	X	
2	Content can be verified by other sources.	X	
3	Document is clear and easy to understand.	X	
4	Language / words in document: meaning is known to the researcher.	X	
5	Evidence of alteration or missing content.		X
6	Purpose of document: publication to an audience.	X	
7	Purpose of the document: private use.		X
	Section B: Author		
1	Author's background is known.	X	

2	Author's biases and / or prejudices were considered.	X	
3	Literary style is similar to other documents by the same author.	X	
4	Author was removed from event – in physical / time dimension.		X
5	Author was involved in historical event.	X	
6	Events were recorded accurately (no evidence to the contrary).	X	
7	Author was willing / able to record the truth.	X	
8	In writing the document, author stands to gain personal advantage.		X

Three Documents included in the research project: YES

Motivation: Acknowledged specialist in South African nursing history.

Example 5: Secondary source: article

Imperial Nursing: Cross-Cultural Challenges for Women in Health Professions: A Historical Perspective.

Date accessed: October 2011

Library / Archive / private collection / ☒ online data base:

Primary / ☒ secondary source:

Authenticity: original document / ☒ copy

Author: Schultheiss, K

Date written / published: 2010

Type: ☒ empirical data / personal opinion / anecdotal account

Historical documents: inclusive criteria

	Criteria	Yes	No
	Section A: Document		
1	Document is relevant to research objectives.	X	
2	Content can be verified by other sources.	X	
3	Document is clear and easy to understand.	X	
4	Language / words in document: meaning is known to the researcher.	X	
5	Evidence of alteration or missing content.		X
6	Purpose of document: publication to an audience.	X	
7	Purpose of the document: private use.		X
	Section B: Author		
1	Author's background is known.	X	
2	Author's biases and / or prejudices were considered.	X	
3	Literary style is similar to other documents by the same author.	NA	
4	Author was removed from event – in physical / time dimension.	X	
5	Author was involved in historical event.		X

6	Events were recorded accurately (no evidence to the contrary).	X	
7	Author was willing / able to record the truth.	X	
8	In writing the document, author stands to gain personal advantage.		X

Document included in the research project: YES

Motivation: European sociologist discussing the social status of nurses.

Discussion includes African nurses.

ANNEXURE C

DECLARATION OF RESEARCHER'S ETHICAL COMPLIANCE

	Ethical compliance criteria	Yes	No
1	Historical research methodology is evident.	X	
2	There is evidence of academic honesty in the researcher's data analysis and interpretation.	X	
3	The historical truth is represented in a responsible manner.	X	
4	Researcher's biases are controlled by evidence of reflection.	X	
5	No person's (alive / deceased) reputation is falsely injured.	X	
6	No evidence of plagiarism.	X	
7	All sources are acknowledged by means of a comprehensive bibliography.	X	
8	Text references are evident in the research document.	X	



Signed: J.M. Esterhuizen

Student nr: 3009 5158

Date: 14 December 2012

ANNEXURE D

REFLECTION

I am a white South African nurse educator whose students are predominantly black South Africans.

Before embarking on the research reported on in this dissertation, I firmly believed that my students should find the resolve to rise above the often insurmountable social and economic problems facing them and excel in nursing theory and practice. Their perceived lack of academic ability at times frustrated me, but I could never pinpoint the exact reasons for this. In addition, my task as a nurse educator was made more complex by the prevailing sociocultural differences between myself and my students. They could not relate to my world, nor could I relate to theirs.

The research on which this dissertation is based clarified the historical and, to a certain extent, current barriers preventing my students from achieving academic excellence. It became evident to me that black South African nurses are a remarkable group of people; constantly adapting to challenging situations, yet never giving up. I admire that. I similarly realised that, historically, the social, economic, educational and political challenges which confronted black South African nurses in the past still continue to exist.

Given the educational challenges described in this dissertation, I realise that my students are not independent learners and need my guidance and support to develop academic independence. Owing to the political history of our country, I also have to consider the economic and social challenges facing them and utilise all the available systems of support.

As a result of the insights gained in the course of my research, I am able to acknowledge and celebrate our cultural differences while supporting my students on their academic journey towards becoming professional South African nurses. Finally, I am able to share a portion of our uniquely South African nursing history with students and colleagues alike.

ANNEXURE E

EDITOR'S DECLARATION

ANNEXURE E: EDITOR'S DECLARATION

8/12/2012

A. Harold

BA (Hons), MA (Wits); BA (Hons), MA (Cum Laude), HED (Unisa)
Professional Editor/Sworn Translator of the High Court of South Africa
Member of the Professional Editors' Group (PEG)
Postal Address: 604 Cartwright's Corner, 19 Adderley Street, Cape Town 8001, South Africa
Tel.: 021 461-1483/Cell.: 072 414 0064
Email: alby01@telkomsa.net


8 December 2012

EDITOR'S DECLARATION

I have pleasure in certifying that I have edited the language of the MA dissertation submitted to me by **Ms Joan Esterhuizen** but without viewing the final version.

The title of the dissertation is **THE PROFESSIONAL DEVELOPMENT OF BLACK SOUTH AFRICAN NURSES 1908–1994: A HISTORICAL PERSPECTIVE**.

In my professional opinion, the language used in the dissertation is correct, stylistically appropriate, and of a high standard. I therefore believe that the dissertation is ready to be submitted for examination.


A. Harold